

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07623

1. DECEASED-NAME (Type or print) First Middle Last <u>George William Baker</u>			2a. DATE OF DEATH Month Day Year <u>May 29 1968</u>		2b. HOUR M <u></u>
3. SEX <u>Male</u>	4. RACE <u>White</u>	5. DATE OF BIRTH <u>August 9, 1904</u>		6. AGE (In years last birthday) <u>63</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <u>Security, Md.</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <u>Washington</u> Md.		
10. CITY OR TOWN OF DEATH <u>Hagerstown</u>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Washington County Hospital</u>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Salesman</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>Jewel Tea Co.</u>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>	13b. COUNTY <u>Washington</u>	13c. CITY OR TOWN <u>Funkstown</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <u>113 E. Green St.</u>	
14. FATHER'S NAME First Middle Last <u>Samuel Henry Baker</u>		15. MOTHER'S MAIDEN NAME First Middle Last <u>Ida Mae Sanders</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16b. SOCIAL SECURITY NO. <u>214-09-5290</u>		17. INFORMANT Address <u>Mrs. Hazel D. Baker 113 E. Green St. Funkstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>42.01</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>Cancer diagnosed 2 months before death</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>May 29</u> , 19 <u>68</u> , to <u>May 29</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>May 29</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE <u>Sidney Novakstein</u>		22c. DATE SIGNED <u>5-31-68</u>		22d. PHYSICIAN'S NAME (Type) <u>SIDNEY NOVAKSTEIN</u>	
22e. ADDRESS <u>FUNKSTOWN MD</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE <u>6/1/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. C. Horst</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 3 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <i>Everett Higgins BARGER</i>			2a. DATE OF DEATH 5 Month 6 Day 68 Year		2b. HOUR 5:30 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH April 9, 1900		6. AGE (In years last birthday) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) New Freeport, Pa.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH Washington Md.		
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Guard	12b. KIND OF BUSINESS OR INDUSTRY Federal Jail		
13a. USUAL RESIDENCE (Where deceased admitted) STATE Maryland	13b. CITY OR TOWN Washington	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1926 Virginia Ave.		
14. FATHER'S NAME First Middle Last John W Barger	15. MOTHER'S MAIDEN NAME First Middle Last Nell Higgins				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown) Yes	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) WW 2	17. INFORMANT Address Mr. Willard Wenger 1926 Virginia Ave. Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4109 DUE TO, OR AS A CONSEQUENCE OF <u>Anterograde Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Emphysema</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes yrs. yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4301					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State 513 68 516 68			
22a. I certify that (I) (this hospital) attended the deceased from <u>5-6</u> , 19 <u>68</u> , to <u>5-6</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>5-6</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>D. J. Boyer</i>	DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 5-7-68		
22d. PHYSICIAN'S NAME (Type) D. J. Boyer	22e. ADDRESS 136 N. Potomac St. Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/9/68	23c. NAME OF CEMETERY OR CREMATORY Normalville Cemetery	23d. LOCATION (City or Town) (County) (State) Normalville - Fayette - Pa.		
24. FUNERAL DIRECTOR <i>Wm. C. Hoon</i>	ADDRESS Rest Haven Funeral Chapel Hagerstown, Md.	25a. REC'D BY REGISTRAR DATE MAY 8 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last Harry Buhrman Beard						2a. DATE OF DEATH Month Day Year May 30, 1968			2b. HOUR M		
3. SEX male		4. RACE white		5. DATE OF BIRTH 9-25-1886		6. AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. County Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Owner		12b. KIND OF BUSINESS OR INDUSTRY Grocery Store					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Wash.		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 120E Irvin, Ave.			
14. FATHER'S NAME First Middle Last Daniel M. Beard				15. MOTHER'S MAIDEN NAME First Middle Last Agnes R. Leather							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. 218-30-9690		17. INFORMANT Address Mrs. Anna N. Beard Hagerstown, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 403 X Wernia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 446 X (b) Renal insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days many years many years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Acute Gastroenteritis; cerebral arteriosclerosis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from May 25, 1968 , to May 29, 1968 , that (I) (we) last saw the deceased alive on May 29, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Edson B. Moody		DEGREE DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/31/68	
22d. PHYSICIAN'S NAME (Type) Edson B. Moody, M.D.		22e. ADDRESS 363 E. Cleveland Ave. Hagerstown, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-1-1968		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.					
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.				25a. REC'D BY REGISTRAR JUN 4 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

SECTION OF THE PLAN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 2120103622
CERTIFICATE OF DEATH
07626

1. DECEASED-NAME (Type or print) PAUL NELSON BIVENS			2a. DATE OF DEATH Month MAY Day 25 Year 1968		2b. HOUR 2:30 P
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH APRIL 16, 1930		6. AGE (In years last birthday) 38	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH WASHINGTON		
10. CITY OR TOWN OF DEATH HANCOCK	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 206 BAPTIST CHURCH ROAD		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CUSTODIAN	12b. KIND OF BUSINESS OR INDUSTRY PRIMARY SCHOOL	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY WASHINGTON	13c. CITY OR TOWN HANCOCK	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 206 BAPTIST CHURCH RD.	
14. FATHER'S NAME First Middle Last SAMUEL RALPH BIVENS (D)		15. MOTHER'S MAIDEN NAME First Middle Last ANNA GERTRUDE HOKE (LIVING)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 220-28-3927	17. INFORMANT Address HELEN BIVENS SAME AS 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410.9 Coronary Embolism DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arterio Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) 4201					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE L M Shaffer MD		DEGREE MD		22c. DATE SIGNED 5/27/68	
22d. PHYSICIAN'S NAME (Type) L M SHAFFER		22e. ADDRESS HANCOCK MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 5/28/68	23c. NAME OF CEMETERY OR CREMATORY CEDAR LAWN MEMORIAL		23d. LOCATION (City or town) (County) (State) HAGERSTOWN, WASH., MD	
24. FUNERAL DIRECTOR Richard J. Stone		ADDRESS HANCOCK, MD.		25a. REC'D BY REGISTRAR DATE MAY 31 1968	25b. REGISTRAR'S SIGNATURE Charles Judge

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PAUL NELSON EIVING MAY 22, 1958 2:30 P

MALE WHITE APRIL 12, 1930 BR
PENNSYLVANIA U.S.A.
WASHINGTON
HAROCK 208 BAPTIST CHURCH ROAD
MARYLAND WASHINGTON HAROCK X
SAMUEL RALPH EIVING (D) ANNA PETRUDE (KORE LIVING)
NO 100-88-3857 WELLEN EIVING BAPT AS 13

[Faint, illegible handwritten notes and signatures]

DEAR LAM MEMORIAL HAGERSTOWN, WASH., MD
HAROCK, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Amber Georgie Brennan			2a. DATE OF DEATH Month May Day 24 Year 1968			2b. HOUR M 					
3. SEX Female		4. RACE White		5. DATE OF BIRTH Jan. 16, 1881		6. AGE (In years lost birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (State or foreign country) Chicora, Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.					
10. CITY OR TOWN OF DEATH Clear Spring, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cumberland St.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) House work			12b. KIND OF BUSINESS OR INDUSTRY Home duties		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Clear Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER None		
14. FATHER'S NAME First George Middle W Last Putnam			15. MOTHER'S MAIDEN NAME First Harriet Middle # Last Stewart								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service) None			16b. SOCIAL SECURITY NO. None		17. INFORMANT Address Stewart Brennan Clear Spring, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) general arteriosclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 5-24 , 19 68 , to 5-24 , 19 68 , that (I) (we) lost saw the deceased alive on 5-24 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Francisco E. Rosillo		DEGREE MD		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 5807 modern Ave. Hagerstown									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/27, 68		23c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery		23d. LOCATION (City or Town) (County) (State) Clear Spring, Md.					
24. FUNERAL DIRECTOR Margaret Rawland		ADDRESS Clear Spring, Md.		25a. REC'D BY REGISTRAR DATE MAY 28 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

1933

CHURCH OF JESUS

1933

Member	George	Thomas	Ray	1933
Female	White	Jan. 10, 1933		
Member, Jr.				
Officer, Jr.	W. C. Johnson			
Member	William			
Member	Thomas			
Member	Thomas			

The undersigned
 William Johnson
 Thomas Johnson

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 1933

William Johnson
 Thomas Johnson

Thomas Johnson
 William Johnson

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Thomas Johnson
 William Johnson

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30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

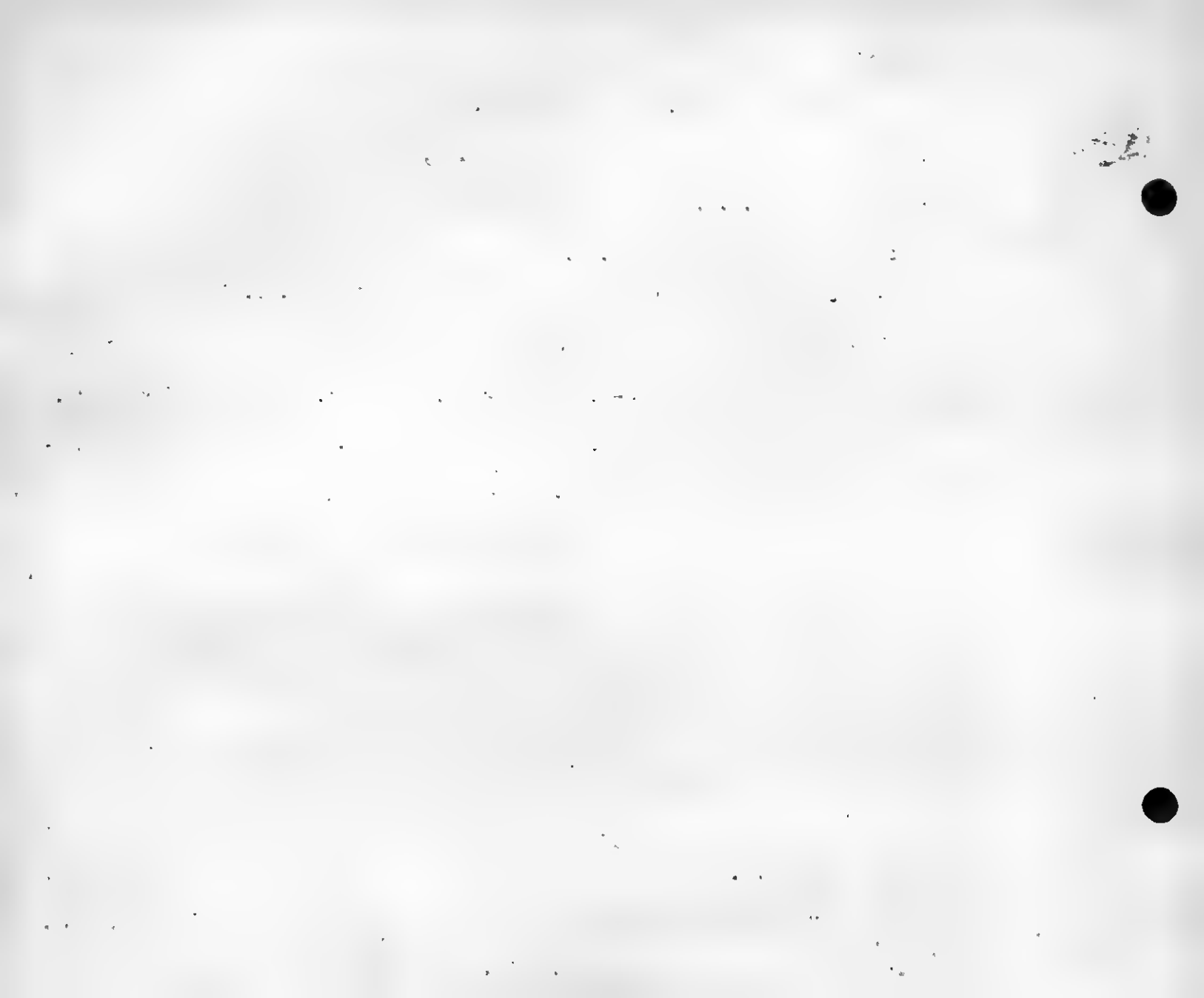
1. DECEASED-NAME (Type or print) Charles Albert Brown, Jr.			2a. DATE OF DEATH Month May Day 1 Year 1968			2b. HOUR 10:30 A.M.						
3. SEX male		4. RACE white		5. DATE OF BIRTH 12-8-1915		6. AGE (In years last birthday) 52 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0		
7a. BIRTHPLACE (State or foreign country) North Dakota		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington			Md.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 380 McDonald Ave.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Manager			12b. KIND OF BUSINESS OR INDUSTRY Food Industry				
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b. COUNTY Wash. Hagerstown		13c. CITY OR TOWN YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1717 WoodCrest, Road.						
14. FATHER'S NAME First Charles A. Middle Brown, Sr. Last Green			15. MOTHER'S MAIDEN NAME First Gladys Middle - Last Green									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO		17. INFORMANT Mrs. Phyllis R. Brown Hagerstown, Md.			Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last minutes years											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4 + - 1												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from Nov , 19 64 , to May 1 , 19 68 , that (I) (we) last saw the deceased alive on Apr 30 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Charles C. Spencer					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED May 2, 1968					
22d. PHYSICIAN'S NAME (Type) Charles C. Spencer M. J.					22e. ADDRESS 145 South Prospect Street							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-4-1968		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.					
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.					ADDRESS		25a. REC'D BY REGISTRAR MAY 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Ella Mae Buffington			2a. DATE OF DEATH May Month 1 Day 1968 Year			2b. HOUR 7:15 P.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH Feb. 7, 1900		6. AGE (In years last birthday) 68 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md				
10. CITY OR TOWN OF DEATH Cascade			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) R. D. 1			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Cascade		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER R. D. 1	
14. FATHER'S NAME First Middle Last Henry Pollard			15. MOTHER'S MAIDEN NAME First Middle Last Ella Arrington							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 220-28-8168		17. INFORMANT Address Elmer W. Harrison, Blue Ridge Summit Pa.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>2 years</u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>47.1</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>May 1, 1968</u> , to <u>May 1, 1968</u> , that (I) (we) last saw the deceased alive on <u>30 April 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Robert A. Kiefer</u> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <u>2 May 1968</u>						
22d. PHYSICIAN'S NAME (Type) Robert A. Kiefer				22e. ADDRESS <u>Blue Ridge Summit, Penna.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/5/68		23c. NAME OF CEMETERY OR CREMATORY Bethel			23d. LOCATION (City or Town) (County) (State) Lantz #1 Frederick Md.			
24. FUNERAL DIRECTOR <u>Walter G. Grove</u>				ADDRESS Waynesboro Pa.			25a. REC'D BY REGISTRAR DATE MAY 6 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
Duane A. Buhrman						Month Day Year			5 2 1968		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER YEAR	8 UNDER 24 HRS	2c DATE PRONOUNCED DEAD			2d HOUR		
male	white	4-23-60	YRS MONTHS DAYS	9		Month Day Year			5 2 1968		
7a BIRTHPLACE (State or foreign country)			7b CIT ZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
Md.			USA						Washington Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown			Washington Co. Hosp.			None					
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Md.			Fred.			Lantz			RD 1		
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last								
Arthur L. Buhrman			Priscilla Bowman								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS		
No			None			Arthur E. Buhrman			Lantz, Md. RD 1		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SDIT Aspiration vomitus.											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause lost											
(b) suspected hypoplastic adrenal cortex											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
7593											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			P.M. 19								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or town County State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			EDWARD W. DITTO III M.D.			DEPUTY MEDICAL EXAMINER			5-2-68		
			ADDRESS (Street, city, town, or county)								
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			5-4-68			Mt. Bethel Meth. Cem.			Foxville Fred. Co. Md.		
24 FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Raymond E. Creager			Raymond E. Creager, Thurmont, Md.			DATE MAY 6 1968			Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-54

Item#5 Film#400 5/17/68 ph
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Raymond Francis Burkner			2a. DATE OF DEATH Month Day, Year May 11, 1968		2b. HOUR 9:30 PM
3. SEX Male	4. RACE White		5. DATE OF BIRTH 4/2/83 May 11, 1983		6. AGE (In years last birthday) 85 YRS
7a. BIRTHPLACE (State or foreign country) Luray, Va.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Washington		Md.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Labor	
12b. KIND OF BUSINESS OR INDUSTRY Construction					
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. CITY OR TOWN Boonsboro		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13d. STREET AND NUMBER Rfd. 2					
14. FATHER'S NAME First Middle Last Thomas F. Burkner			15. MOTHER'S MAIDEN NAME First Middle Last Virginia Breedon		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) Yes W. W. One		16b. SOCIAL SECURITY NO. 219-20-3426		17. INFORMANT Address Mr. Marvin Burkner, Rfd. 2, Boonsboro, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Heart Failure</u> 41 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 years years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4100 none					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4-8-1960 to 5-11-1968, that (I) (we) last saw the deceased alive on 5-11-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J. H. Seconari		DEGREE ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. DATE SIGNED 5.12.68					
22d. PHYSICIAN'S NAME (Type) JOSEPH SECONARI		22e. ADDRESS Boonsboro Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-14-68		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	
23d. LOCATION (City or Town) Hagerstown, Wash. Co., Md.					
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		ADDRESS		25a. REC'D BY REGISTRAR MAY 15 1968	
25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last Beulah May Bussard			2a. DATE OF DEATH Month Day Year May 8, 1968		2b. HOUR 1:50A M
3 SEX Female	4 RACE White	5 DATE OF BIRTH August 25, 1892		6. AGE (In years last birthday) 75 YRS. 8 MONTHS 13 DAYS	
7a. BIRTHPLACE (State or foreign country) Chestnut Grove, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Washington Md.					
10. CITY OR TOWN OF DEATH Hagerstown		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY Own Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Keedysville	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rfd. 1			
14. FATHER'S NAME First Middle Last Charles Holmes			15. MOTHER'S MAIDEN NAME First Middle Last Ellen Jamison		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No.		16b. SOCIAL SECURITY NO None		17 INFORMANT 846 Kenly Ave. Mr. Frank G. Bussard, Hagerstown, Md. 21740	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>myocardial infarction</u> 410.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1. <u>Diabetes mellitus with aneurysm of heart</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>5/7</u> , 19 <u>68</u> , to <u>5/8</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>5/7</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>R. Amarillo</u>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>5/8/68</u>	
22d. PHYSICIAN'S NAME (Type) <u>R. Amarillo, M.D.</u>		22e. ADDRESS <u>Sharpsburg, Md 21782</u>			
23a. BURIAL, CREMATION, REMAINS (Type) <u>Buried</u>		23b. DATE <u>5-10-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Samples Manor Cemetery</u>	
23d. LOCATION (City or Town) (County) (State) <u>Samples Manor, Wash. Co., Md.</u>					
24. FUNERAL DIRECTOR <u>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</u>		ADDRESS		25a. REC'D BY REGISTRAR DATE <u>MAY 13 1968</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

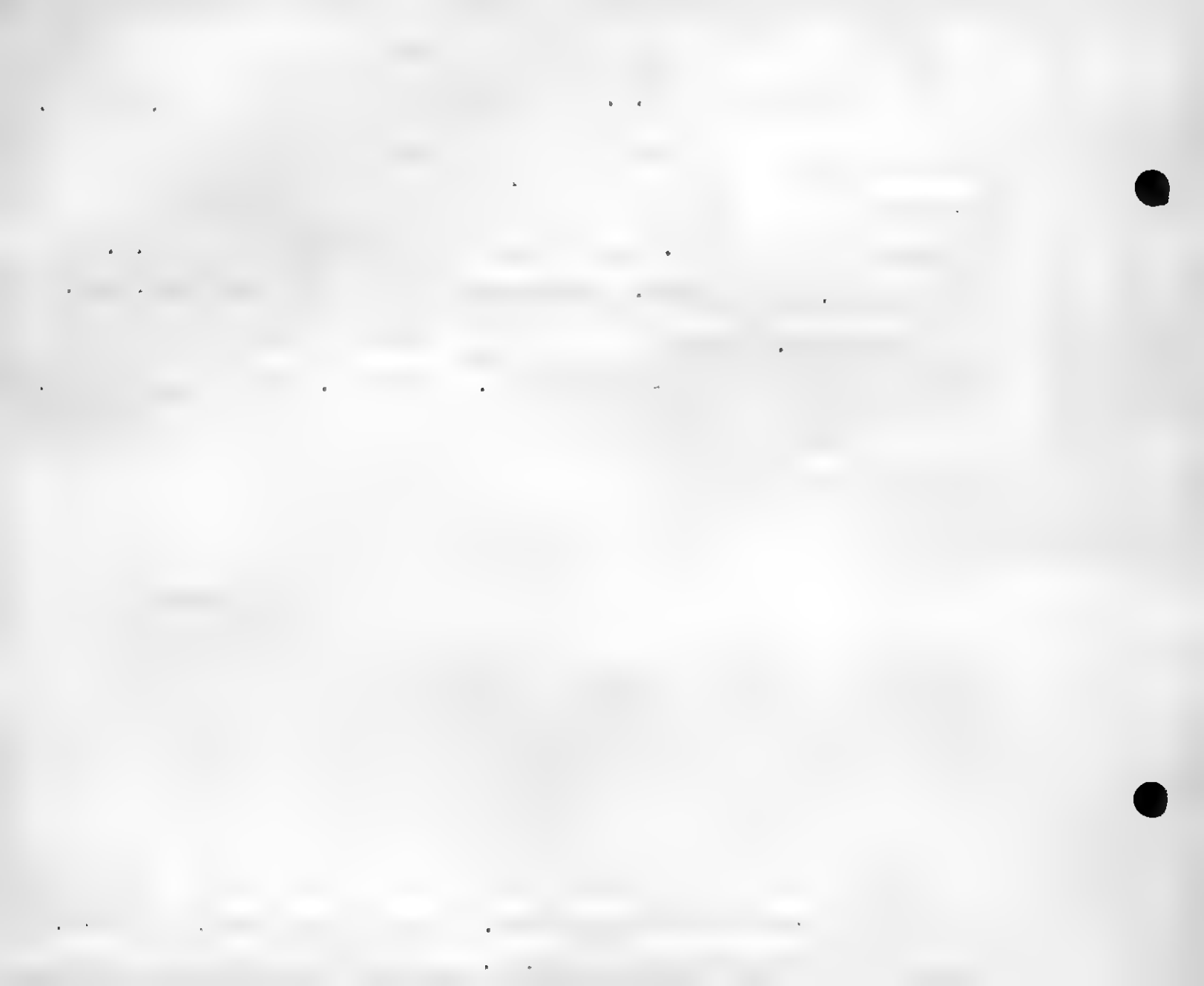
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR P.
Collins			N.M.N	Cameron	May 13, 1968		9:45 M
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	
male	white		3-13-1913		55 YRS.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Alabama	USA				Washington Md		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown	Wash. County Hospital		Colonel		U.S. Army		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
Md.	Wash.		Hagerstown		1430 Hamilton, Blvd.		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last				
Robert E. Cameron			Minnie Collins				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Address			
Yes		349-28-6730		Mrs. Mildred C. Cameron Hagerstown, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> 4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 hr.</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 40							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>May 1967</u> to <u>13 May 1968</u> , that (I) <u>two</u> last saw the deceased alive on <u>13 May 1968</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>was</u> (did) (did not) view the body after death.							
22b. SIGNATURE <u>J.D. Wilson</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>5/14/68</u>	
22d. PHYSICIAN'S NAME (Type) <u>J.D. WILSON</u>				22e. ADDRESS			
23g. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		5-16-1968	Arlington Nat. Cemetery		Fort Meyer, Virginia.		
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Minnich Funeral Home Hagerstown, Md.				DATE MAY 17 1968		<u>J. Charles Jones</u>	



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last William Carmela Capotosti			2a. DATE OF DEATH Month Day Year May 9, 1968			2b. HOURS 7:47 P.M.	
3 SEX male		4 RACE white		5. DATE OF BIRTH 5-2-1923		6. AGE (In years last birthday) 45 YRS.	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. County Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Spot Welder		12b. KIND OF BUSINESS OR INDUSTRY Aircraft, Mfg	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Wash. Hagerstown		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER R.F.D. #4							
14. FATHER'S NAME First Middle Last Frank - Capotosti				15. MOTHER'S MAIDEN NAME First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) yes WW - II		16b. SOCIAL SECURITY NO. 190-16-5438		17. INFORMANT Address Mrs. Betty Capotosti Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) 410-4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours 5 years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION 5-9-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 5-2-68 , 19 68 , to 5-9-68 , 19 68 , that (I) (we) lost saw the deceased alive on 5-9-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Charles F. Hess				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5-10-68	
22d. PHYSICIAN'S NAME (Type) Charles F. Hess, M.D.				22e. ADDRESS Smithsburg, Maryland 21723			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-13-1968		23c. NAME OF CEMETERY OR CREMATORY Salem Reformed Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR ADDRESS Minnich Funeral Home Hagerstown, Md.				25a. REC'D BY REGISTRAR 13 1968			

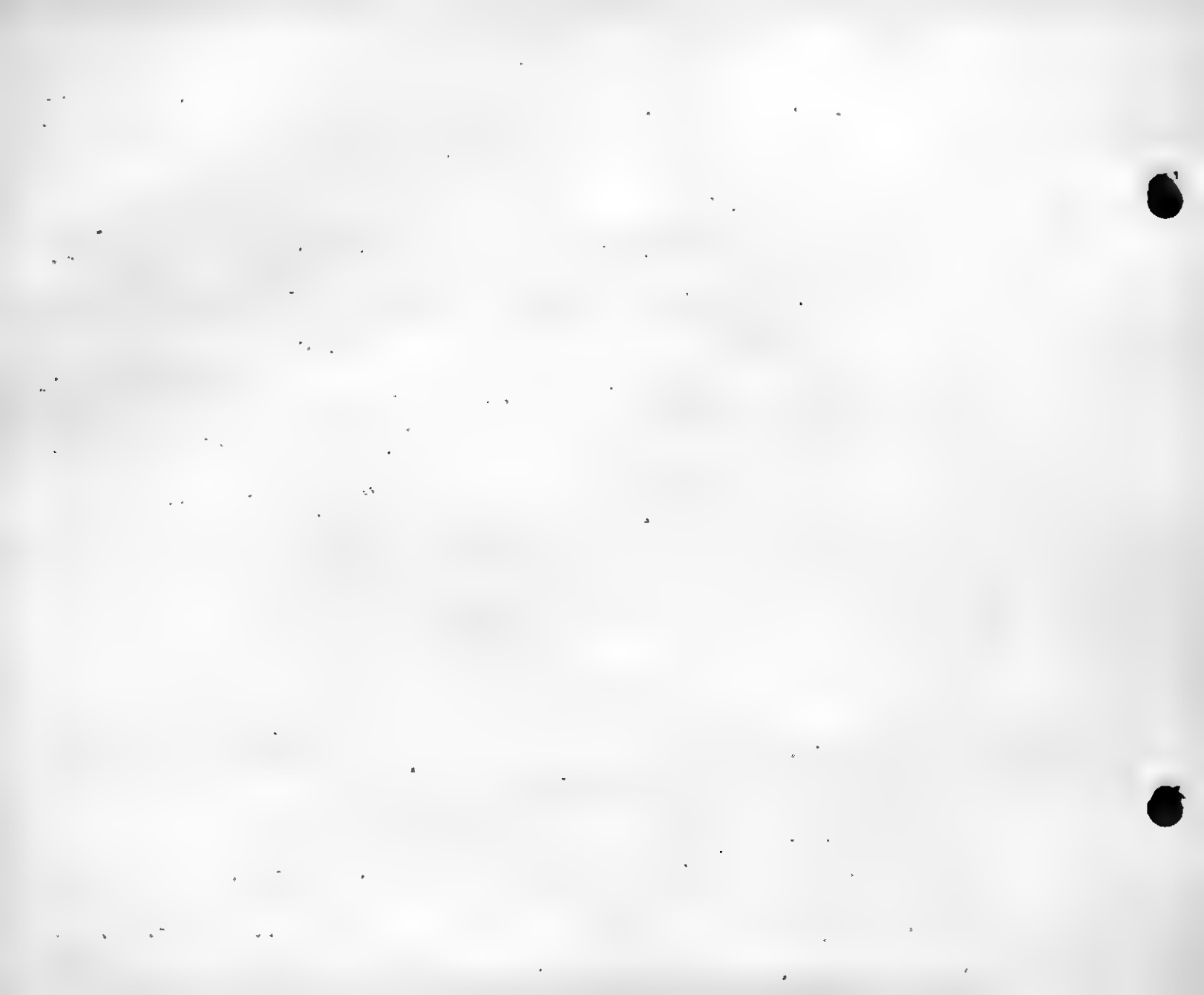
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last MELVIN J. CARSON			2a. DATE OF DEATH Month Day Year 5 / 9 / 68			2b. HOUR 9:38 M			
3 SEX MALE		4. RACE WHITE		5. DATE OF BIRTH FEBRUARY 16, 1905		6. AGE (In years last birthday) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Md			
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GARLOCK NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY & ADV. SPECIALTIES			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MARYLAND		13b. COUNTY WASHINGTON		13c. CITY OR TOWN HAGERSTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 317 NORTH CANNON AVENUE,	
14. FATHER'S NAME First Middle Last UNKNOWN			15. MOTHER'S MAIDEN NAME First Middle Last UNKNOWN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown UNK.		16b. SOCIAL SECURITY NO (If yes give war or dates of service) ***** 216-30-3528		17. INFORMANT MR. ROBERT NOLAND,		16 WEST WILSON BLVD. HAGERSTOWN, MARYLAND.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cause Myocardial Infarction</u> 4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>4-7-68</u> (c) <u>Arteriosclerosis Gen.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 Hrs. Not known Not known									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Hypertension Disease</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from <u>2/3/68</u> to <u>5/9/68</u> , that (I) (we) last saw the deceased alive on <u>5/12/68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Arturo M. Riego</u>		DEGREE ARTURO M. RIEGO, M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/10			
22d. PHYSICIAN'S NAME (Type) ARTURO M. RIEGO, M.D.		22e. ADDRESS 119 EAST ANTIETAM ST. HAGERSTOWN, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5/13/68		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD.			
24. FUNERAL DIRECTOR <u>Charles M. Rieger</u>		ADDRESS HAGERSTOWN, MARYLAND.		25a. REC'D BY REGISTRAR DATE MAY 15 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

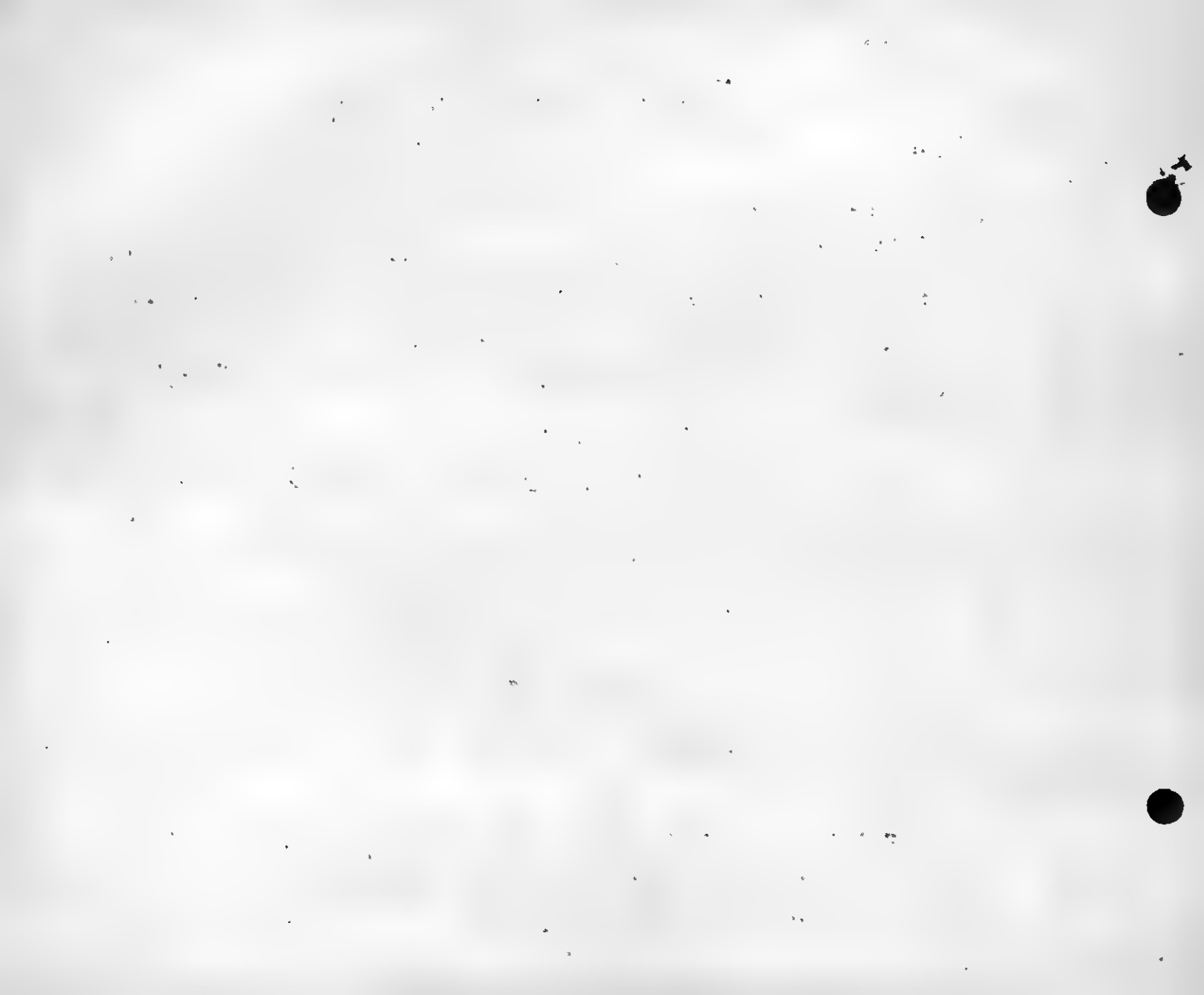


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) JOHN JOSEPH CASSIDY SR.			2a. DATE OF DEATH May Month 24 Day 68 Year		2b. HOUR 2:15pm
3 SEX MALE	4 RACE WHITE	5. DATE OF BIRTH APRIL 27, 1895		6. AGE (in years lost birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Md.	
10. CITY OR TOWN OF DEATH HAGERSTOWN, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED POLICE OFFICER MD. STATE	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE HAGERSTOWN		13b. COUNTY WASHINGTON	13c. CITY OR TOWN HAGERSTOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 1810 GILBERT AVE.
14. FATHER'S NAME First Middle Last JOHN T. CASSIDY			15. MOTHER'S MAIDEN NAME First Middle Last ELIZABETH LAUTERBACH		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 218-40-4119		17. INFORMANT RUTH M. CASSIDY Address 1810 GILBERT AVE. HAGERSTOWN, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic Heart Disease in Progress DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 minutes
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 7-19 , 19 64 , to 5-18 , 19 68 , that (I) (we) last saw the deceased alive on 5-18 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE E.R. Lardizabal M.D.		DEGREE MD		22c. DATE SIGNED 5/25/68	
22d. PHYSICIAN'S NAME (Type) E.R. LARDIZABAL M.D.		22e. ADDRESS 300 N. POTOMAC ST HAGERSTOWN, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5/28/68		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEM.	
24. FUNERAL DIRECTOR Charles M. [Signature]		ADDRESS HAGERSTOWN, MD.		25a. REC'D BY REGISTRAR DATE MAY 31 1968	
				25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Francis Massey Castle			2a. DATE OF DEATH Month May Day 15 , Year 1968			2b. HOUR 12:30 AM	
3 SEX Male		4. RACE White		5. DATE OF BIRTH Nov. 19, 1897		6. AGE (In years lost birthday) 70 YRS. MONTHS 5 DAYS 26	
7a. BIRTHPLACE (State or foreign country) Brownsville, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Washington Md.	
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Public School Teacher		12b KIND OF BUSINESS OR INDUSTRY Education	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Brownsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last Noah Castle		15. MOTHER'S MAIDEN NAME First Middle Last Minnie Hoffmaster					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO W. W. Two 219-36-3794		17. INFORMANT Address Mrs. Marguerite Violet, Brownsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Peritonitis 401.9 DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days years.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1-2- , 19 59 , to 5-26 , 19 68 , that (I) (we) last saw the deceased alive on 5-26- 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE John H. Bast, Jr.				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5-16-68	
22d. PHYSICIAN'S NAME (Type) JOSEPH SECONDARI				22e. ADDRESS Boonsboro Md			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5-18-68		23c. NAME OF CEMETERY OR CREMATORY Brownsville Cemetery		23d. LOCATION (City or Town) (County) (State) Brownsville, Wash. Co., Md.	
24 FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md				25a. REC'D BY REGISTRAR MAY 20 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last James Rush Colston Sr.			2a. DATE OF DEATH Month Day Year May 4 1968			2b. HOUR 6:35 AM								
3. SEX Male		4. RACE Colored		5. DATE OF BIRTH Sept 30 1905		6. AGE (In years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN				
7a. BIRTHPLACE (State or foreign country) Guilford Township, Pa. USA			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> D.VORCED <input type="checkbox"/>			9. COUNTY OF DEATH Washington Md					
10. CITY OR TOWN OF DEATH Hagerstown Md			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Cook			12b. KIND OF BUSINESS OR INDUSTRY Hotel					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 643 Penna. Ave.		
14. FATHER'S NAME First Middle Last Richard Leroy Colston			15. MOTHER'S MAIDEN NAME First Middle Last Eliza McMullen											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown			16b. SOCIAL SECURITY NO. 161-12-1521			17. INFORMANT Address Mrs. Catherine R. Colston 643 Penna. Ave.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Diabetic Acidosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetic Mellitus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Unknown</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>NOVA</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>June 4/66</u> , 19 <u>66</u> , to <u>5/4</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/14</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>Donald E Martin MD</u>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>5/5/68</u>					
22d. PHYSICIAN'S NAME (Type) <u>Donald E. Martin, MD</u>						22e. ADDRESS <u>363 S. Cleveland Ave. Hager, Md.</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>May 7, 1968</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Hebron</u>			23d. LOCATION (City or Town) (County) (State) <u>N. York York Pa.</u>					
24. FUNERAL DIRECTOR <u>John R Watson Jr Hagerstown Md</u>						25a. REC'D BY REGISTRAR DATE <u>MAY 7 1968</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

Item #2a, 2b film **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-10-5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH		<input type="checkbox"/> Month	Day	Year	2b HOUR
GEORGE		NMI	COMBS		5		28	19	68	9:00 PM
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD		Month	Day	Year
M	B	UNKNOWN	APPROX. 48 YRS	MONTHS	DAYS	MAY		28	19	68
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
WILKES, W.VA.		U.S.A.		UNKNOWN		WASHINGTON				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY				
HAGERSTOWN		WASHINGTON COUNTY		CARPENTER		HOUSE BLDG.				
3a USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER		
D.C.		---		WASHINGTON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		209 8th S.E.		
4 FATHER'S NAME		First	Middle	Last	15. MOTHER'S MA DEN NAME		First	Middle	Last	
UNKNOWN					UNKNOWN					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		DEPUTY MEDICAL EXAMINER				
UNKNOWN		244-14-3955		DR. EW DITTO, JR.		WASH. CO., HAGERSTOWN, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SUBDURAL EMPYEMA, RIGHT (POST OPERATIVE)										
DUE TO, OR AS A CONSEQUENCE OF SUBDURAL HEMATOMA, RIGHT PULMONARY EMBOLUS, RIGHT LOWER AND MIDDLE LOBE										10 1/2 Days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION										19b CONDITION FOR WHICH OPERATION WAS PERFORMED?
MAY 18, 1968										MASSIVE SUBDURAL HEMATOMA
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21b INJURY OCCURRED										21d LOCATION (Street or R.F.D. No)
4:00AM May 18, 68										Ran thru barricade on Rt. 806
21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f LOCATION (City or Town)
ST. RT. 806										LEWISTOWN
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE										CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type)										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
E. W. DITTO, JR., M.D.										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
23a BURIAL, CREMATION, REMOVAL (Specify)										23b DATE
BURIAL										6/6/68
23c NAME OF CEMETERY OR CREMATORY										23d LOCATION (City or Town)
ROSE HILL CEMETERY										HAGERSTOWN, WASHINGTON CO., MD.
24 FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR
Charles M. Rayner										DATE JUN 7 1968
HAGERSTOWN, MARYLAND										25b REGISTRAR'S SIGNATURE
										Charles Judge

CERTIFICATE OF DEATH

57500

1. DECEASED-NAME (Type or print) EDITH ELIZABETH COSS			2a. DATE OF DEATH Month 5 / Day 2 / Year 68			2b. HOUR 12:20 A			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH JUNE 13, 1888		6. AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Mo			
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON CO. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired.) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY WASHINGTON		13c. CITY OR TOWN HAGERSTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 419 NORTH MULBERRY STREET	
14. FATHER'S NAME First Middle Last WILLIAM H. SHANK			15. MOTHER'S MAIDEN NAME First Middle Last MARY HUFFER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service) ****		16b. SOCIAL SECURITY NO NOT AVAILABLE		17. INFORMANT MRS. EDNA STOUFFER, 419 N. MULBERRY ST. HAGERSTOWN, MARYLAND.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer small bowel & Hemorrhages stroke 1599 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (my assistant) attended the deceased from 4/30, 1968 to 5/2, 1968 , that (I) (my assistant) saw the deceased alive on 5/2, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE J. D. Wilson		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/3/68			
22d. PHYSICIAN'S NAME (Type) J. D. WILSON, M.D.		22e. ADDRESS 580 NORTHERN AVE. HAGERSTOWN, MARYLAND.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5/4/68		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MARYLAND			
24. FUNERAL DIRECTOR Wilson L. Eichelberger		ADDRESS ROUZER FUNERAL HOME HAGERSTOWN, MARYLAND		25a. RECD BY REGISTRAR DATE MAY 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

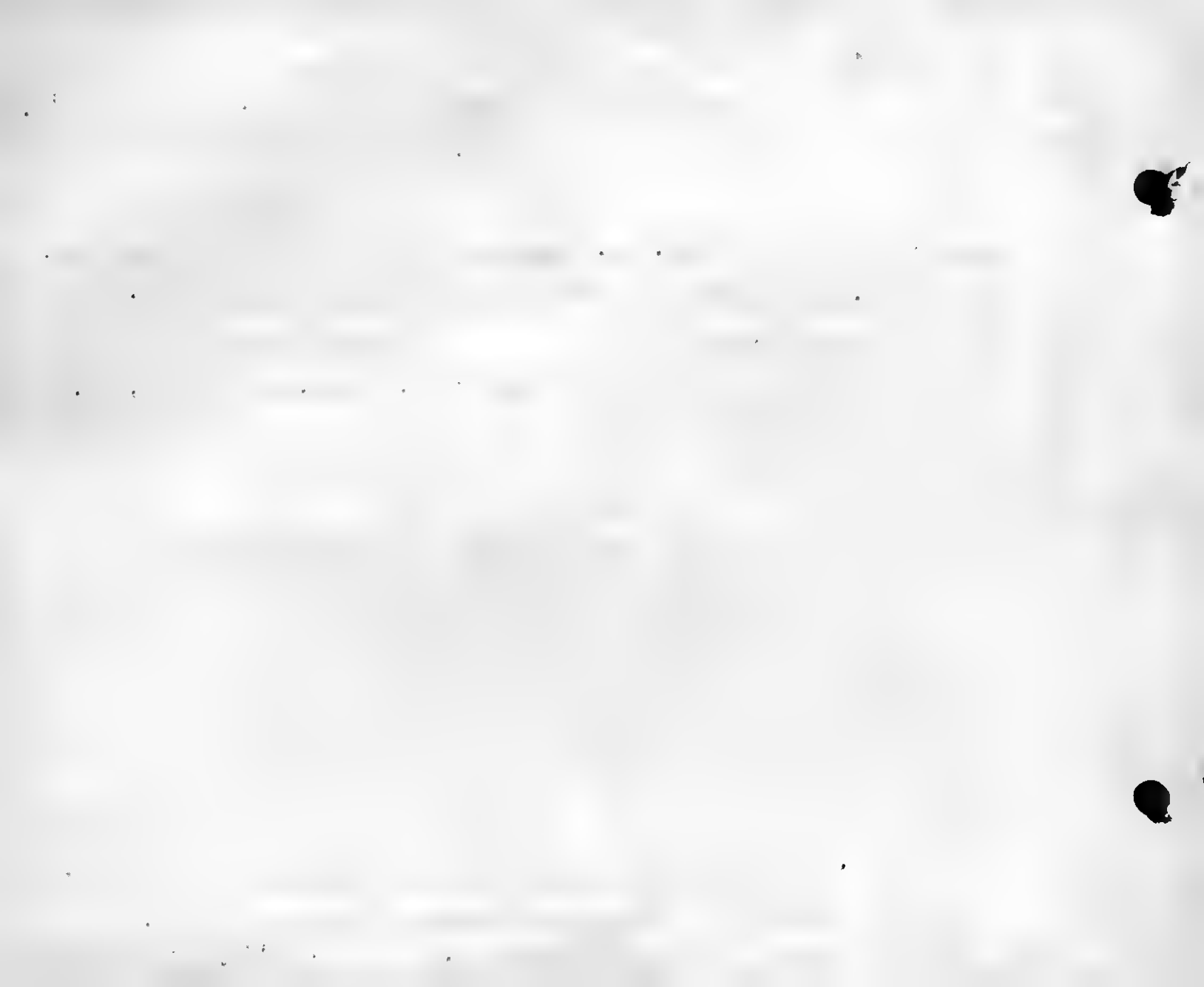
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Martha Washington DeBow			2a. DATE OF DEATH Month May Day 28 , 19 68 Year		2b. HOUR 9:40 P.M.
3. SEX female	4. RACE white	5. DATE OF BIRTH Feb. 22, 1906		6. AGE (In years lost-birthday) 62 YRS.	7. UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. Co. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) general	
12b. KIND OF BUSINESS OR INDUSTRY shoe Mfg.		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 214 James St.			
14. FATHER'S NAME First Abram Middle Hoover Last			15. MOTHER'S MAIDEN NAME First Lillie Middle Kershner Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Charles M. DeBow, Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF Carcinoma of Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo. 8 mo.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Sept. 1967 to 5/28 1968 , that (I) (we) last saw the deceased alive on 5-28 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE D. J. Boyer		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5-29-68	
22d. PHYSICIAN'S NAME (Type) D. J. Boyer, M.D.		22e. ADDRESS 136 N. Potomac Street, Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-1-68		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	
23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.		24. FUNERAL DIRECTOR ADDRESS Minnich Funeral Home, Hagerstown, Md.			
25a. REC'D BY REGISTRAR DATE JUN 3 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

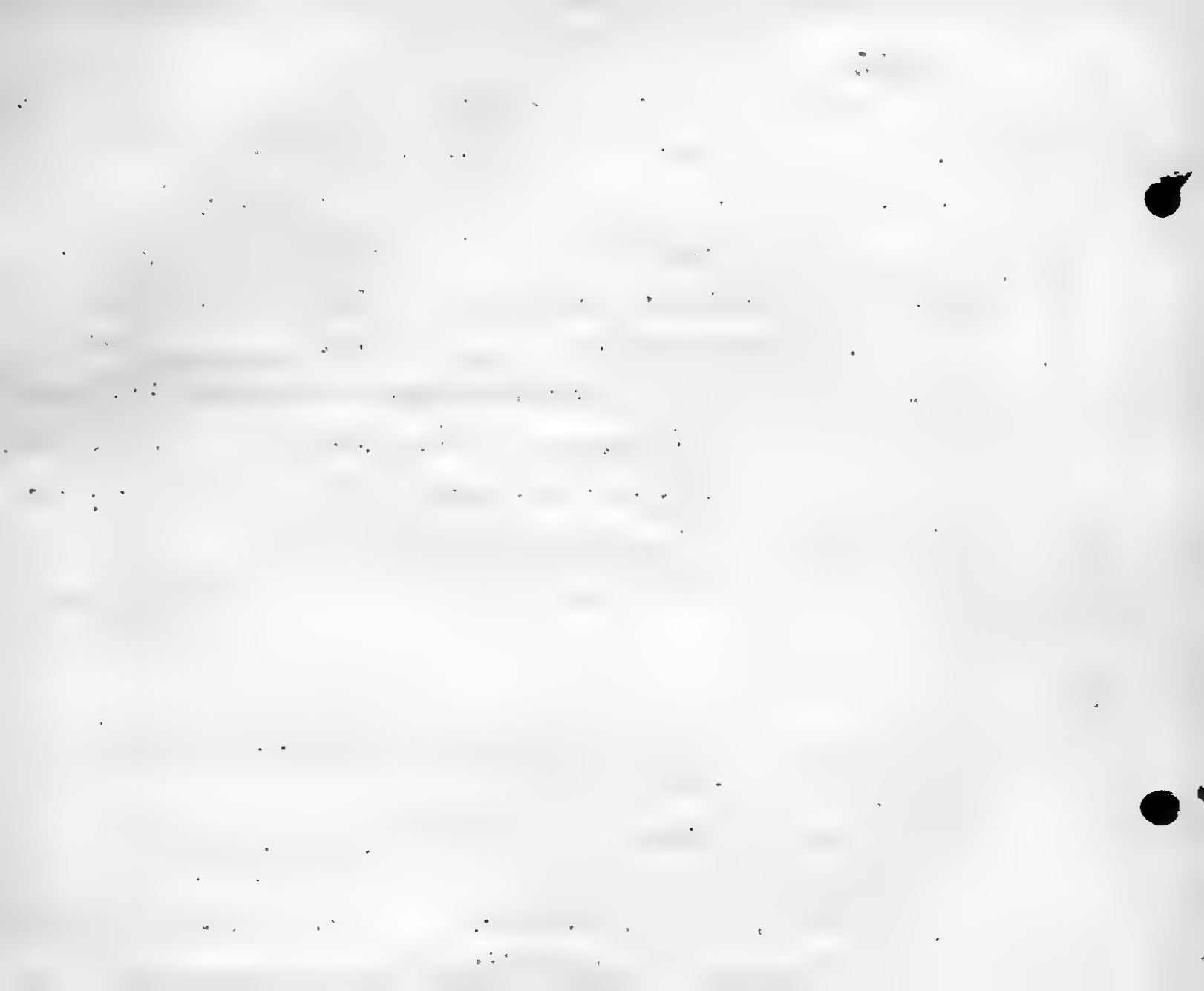


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Rebecca M. Delauder			2a. DATE OF DEATH May 22, 1968		2b. HOUR 10:40 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH Sept. 17, 1881		6. AGE (In years last birthday) 86 YRS.	IF UNDER 1 YEAR MONTHS 8 DAYS 5
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.	
10. CITY OR TOWN OF DEATH Williamsport	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Homewood Church Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY At Home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 19 Reessner Ave.	
14. FATHER'S NAME First Middle Last J. Ellsworth Davis		15. MOTHER'S MAIDEN NAME First Middle Last Sarah Small			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 220-26-2476-J1		17. INFORMANT 21 Coffman Ave. W. Davis Delauder Hagerstown, Maryland 21740	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive C.V. Dis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 47-1					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hours 8 years
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Sept 1, 1968 , to May 22, 1968 , that (I) (we) last saw the deceased alive on 5-16-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert P. Conrad, MD		DEGREE ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		22c. DATE SIGNED 5-23-68	
22d. PHYSICIAN'S NAME (Type) Robert P. Conrad, MD		22e. ADDRESS 137 W. Washington Hagerstown, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE May 24, 1968	23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION (City or Town) (County) (State) Sharpsburg, Washington, Maryland	
24. FUNERAL DIRECTOR Albert L. Leaf		ADDRESS Williamsport, Maryland.		25a. REC'D BY REGISTRAR MAY 27 1968 DATE	
				25b. REGISTRAR'S SIGNATURE W. Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)		First MARCIE G.		Middle	Last DeLauter		2a. DATE OF DEATH May 10 Day 1968		2b. HOUR 7:15 M
3. SEX Female		4. RACE White		5. DATE OF BIRTH Dec. 1, 1902		6. AGE (In years 1st birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md			
1d. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Fred.		13c. CITY OR TOWN Sabillasville		13d. INSIDE CITY LIMITS? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last Jacob M. Gray				15. MOTHER'S MAIDEN NAME First Middle Last May Ridenour					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 215-36-6307		17. INFORMANT George W. DeLauter Sabillasville Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> 4-1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours? at least 4 yrs-									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <u>Diabetes mellitus</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes -			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>5-12, 1968</u> , to <u>5-10, 1968</u> , that (I) (we) last saw the deceased alive on <u>5-10, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John H. Hornbaker, M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5-10-68			
22d. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.		22e. ADDRESS 154 West Washington St., Hagerstown, Md. 21740							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5-13-68		23c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cemetery		23d. LOCATION (City or Town) (County) (State) Thurmont Fred. Co. Md.			
24. FUNERAL DIRECTOR Raymond S. Greger		ADDRESS Thurmont, Md.		25a. REC'D BY REGISTRAR DATE MAY 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



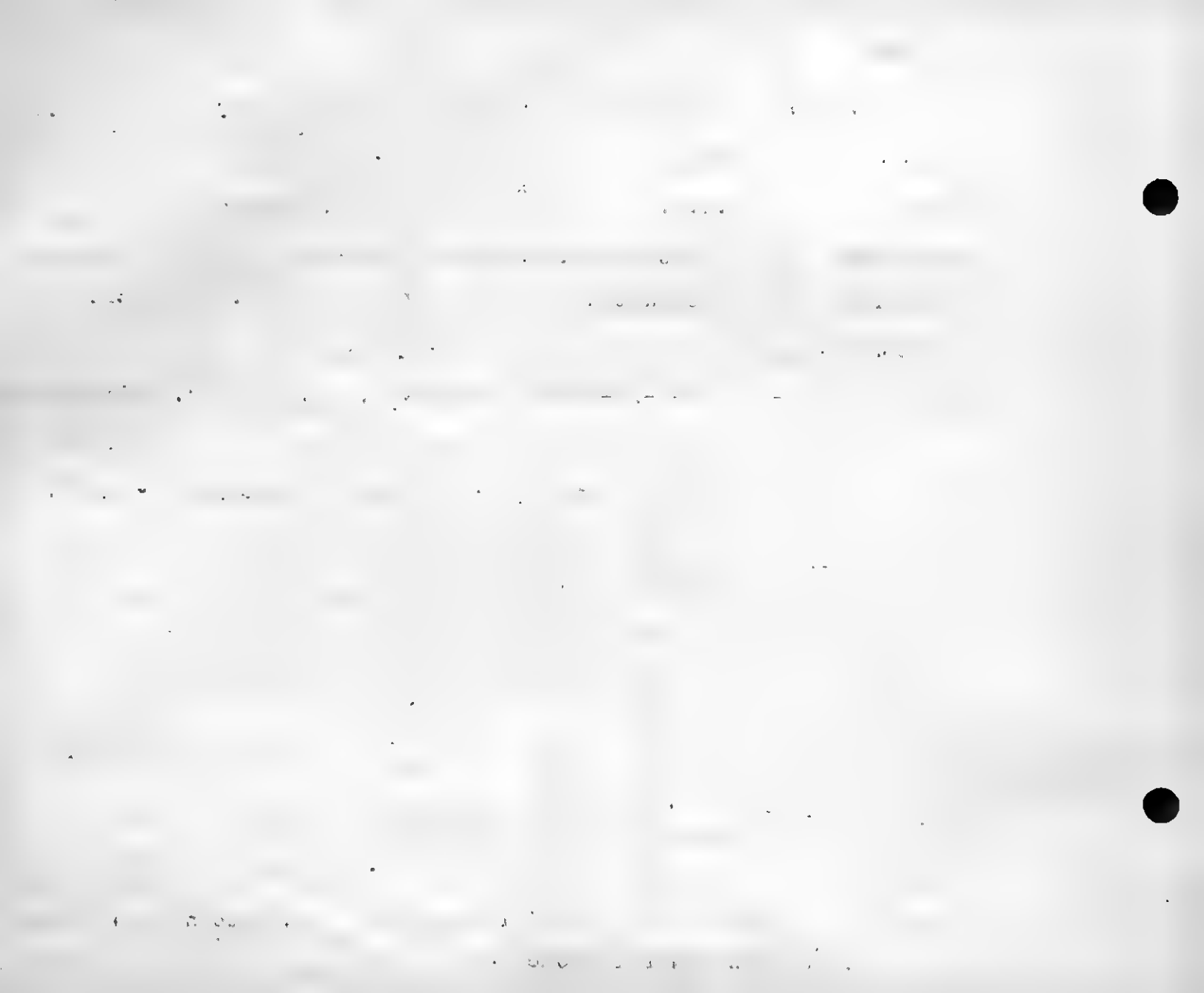
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VR A15 (4)
304 REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR A HOUR		
HOWARD WILLIAM DUNCAN						May 3 1968			4.15 PM		
3 SEX		4 RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		White		May 16 1893			74 YRS.		12 UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md		
Penna		U.S.A.				Washington					
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown			Wash County Hospital			Laborer			Retired		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Washington						26 W. Baltimore St			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Upton Duncan						Anna Reyer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17 INFORMANT			Address		
No			A 188-12-4953			Mrs Mary E. Duncan			26 W. Baltimore St		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u> <u>10 yrs</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>422</u> <u>Diabetes mellitus</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
None											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>1961</u> , to <u>May 3, 1968</u> , that (I) (we) last saw the deceased alive on <u>May 2, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>M.E. Byrkit</u> M.P. DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>5-5-68</u>			
22d. PHYSICIAN'S NAME (Type) <u>M.E. Byrkit</u>						22e. ADDRESS <u>Williamspont Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial		5/6/68		Rose Hill Cemetery			Hagerstown Wash Co Md				
24. FUNERAL DIRECTOR <u>Hagerstown</u> <u>Andrew K. Coffman Funeral Home Inc</u>				ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
						MAY 7 1968					



FOR STATE HEALTH DEPT.

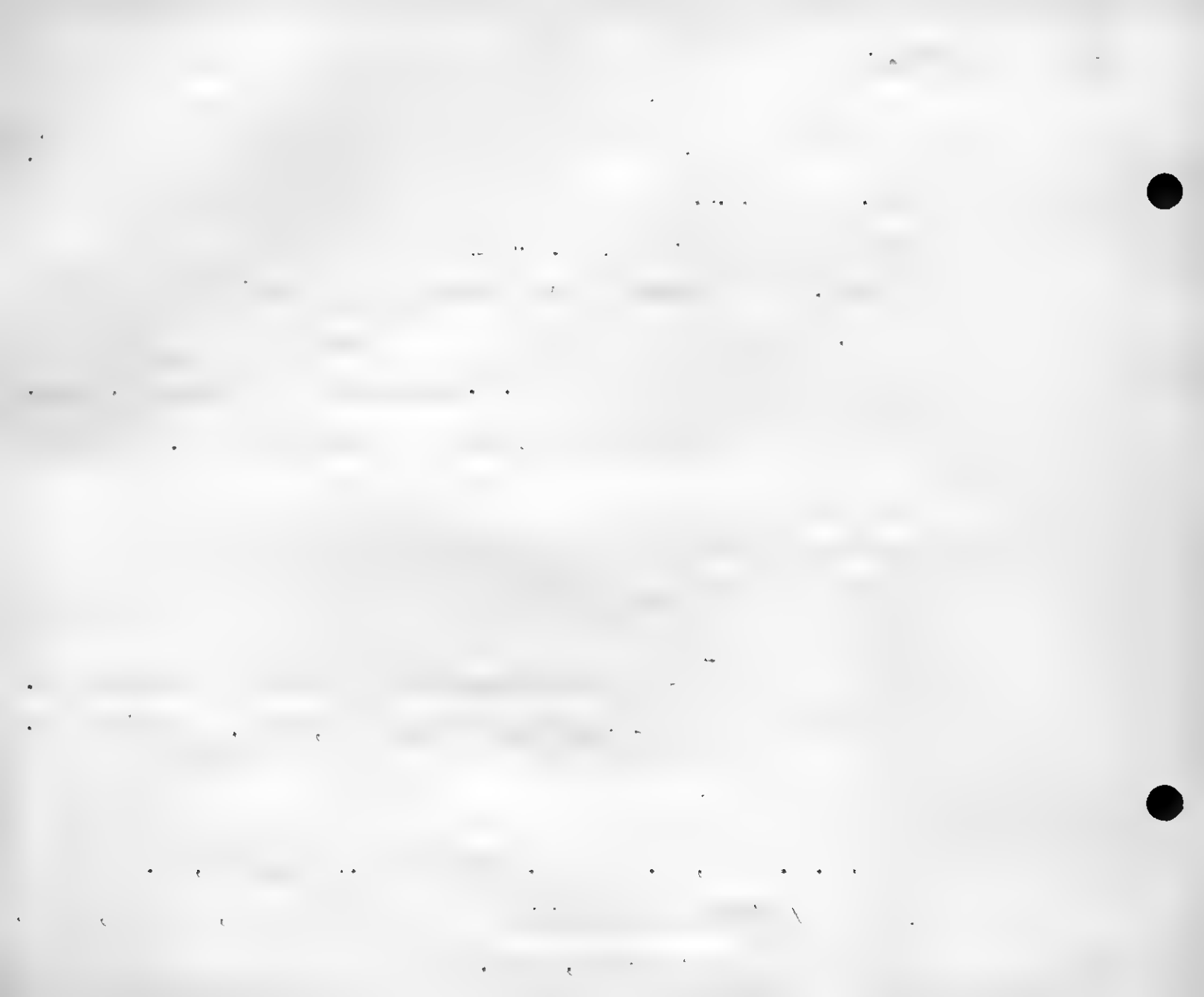
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH		Month	Day	Year	2b HOUR	
Sharon Irene Embly					MAY 27 19 68		May	27	19 68	M	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		
Female	White	July 25, 1952		15 YRS	MONTHS DAYS		HOURS MIN		May 27 19 68 P. M.		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Penna.		U.S.A.				Washington County Md					
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Hagerstown				Washington Co. Hospital				Student			
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Penna.				Franklin		Rouzeville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Box 109	
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME							
First Middle Last				First Middle Last							
H. Mitchell Embly				Edna Swope							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
no				-- --		Mr. H. Mitchell Embly Box 109 Rouzeville, Penna.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intracranial Hemorrhage With Brain Stem Damage.										3 1/2 hours	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION										20 AUTOPSY?	
19b CONDITION FOR WHICH OPERATION WAS PERFORMED?										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
				5:55 P.M. 5-27-1968		Passenger in auto accident with another car.					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e PLACE OF INJURY (At Home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No. City or Town County State					
				State Route 16 - 1/2 mile east of Waynesboro, Penna.		Franklin Pa.					
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b DATE SIGNED			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER				5/28/68			
Dr. E. W. Ditto, Jr.				215 W. Washington St., Hagerstown, Md. 21740							
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
Burial		5/30/1968		Green Hill		Waynesboro, Franklin, Penna.					
24 FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Walter J. Sear				Waynesboro, Penna.				DATE MAY 31 1968		[Signature]	

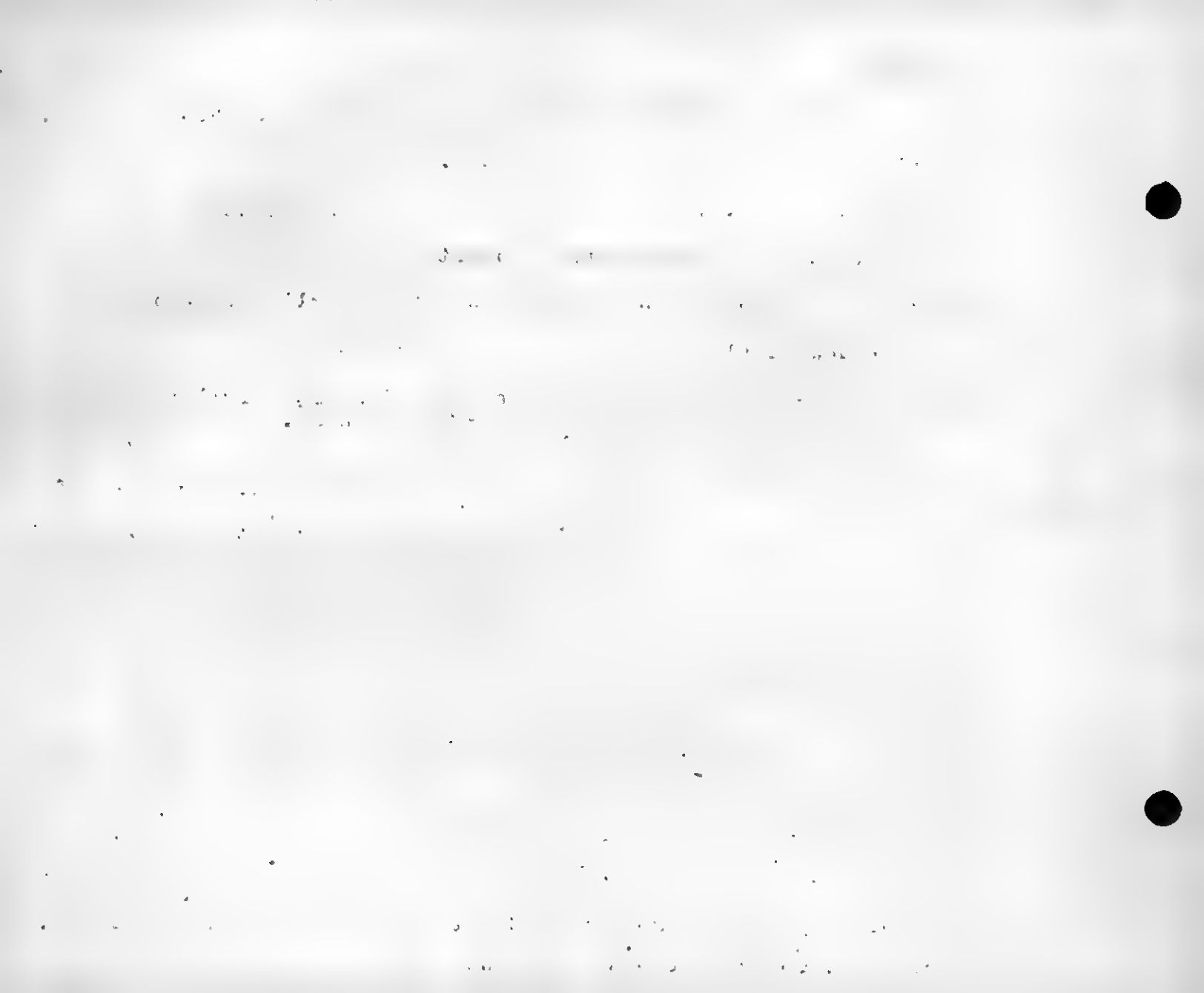


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last JAMES RUSSELL FLEET			2a. DATE OF DEATH Month Day Year May 23 1968			2b. HOUR 10.30			
3 SEX Male		4. RACE White		5 DATE OF BIRTH Nov. 3 1908		6 AGE (In years last birthday) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.			
10. CITY OR TOWN OF DEATH Hagerstown		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash County Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Shoe Co		12b. KIND OF BUSINESS OR INDUSTRY Stitcher			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 311 Jefferson St	
14 FATHER'S NAME First Middle Last Frank R. Fleet			15. MOTHER'S MAIDEN NAME First Middle Last Bessie Cooper						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. ----		17. INFORMANT Address Mrs Ruth Highbarger 1011 Main Ave				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF Pulmonary Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Fibrosis of Lungs DUE TO, OR AS A CONSEQUENCE OF (c) 10 yrs. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from May 19 1968 , to May 23 1968 , that (I) (we) last saw the deceased alive on May 23 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE J. H. Beachley		22c. DATE SIGNED May 23/68		22d. PHYSICIAN'S NAME (Type) J. H. Beachley		22e. ADDRESS Hagerstown Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/25/68		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md.			
24. FUNERAL DIRECTOR Andrew K. Coffman				25a. REC'D BY REGISTRAR May 31 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



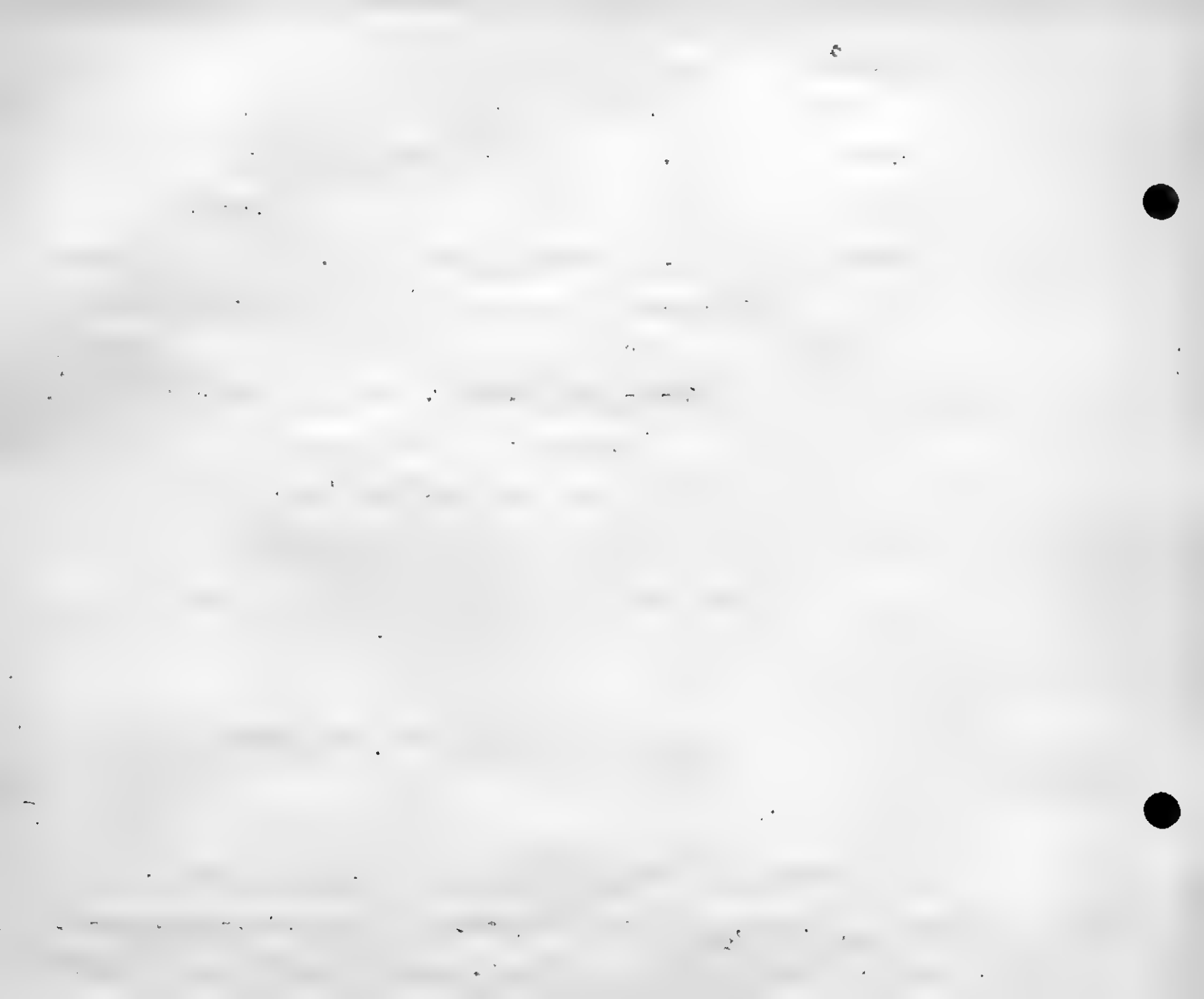
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VR A
30M REV 7-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First <i>Lina</i> Middle <i>Mocker</i> Last <i>Franz</i>			2a. DATE OF DEATH Month <i>May</i> Day <i>10</i> Year <i>1968</i>			2b. HOUR <i>345A</i>	
3 SEX <i>Female</i>		4 RACE <i>White</i>		5. DATE OF BIRTH <i>September 12, 1890</i>		6 AGE (in years last birthday) <i>77</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Germany</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Washington</i> Md.	
10 CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Jackson Convalescent Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of workup, if even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>233 Mealey Parkway</i>		14. FATHER'S NAME First <i>Philip</i> Middle <i>Mocker</i> Last <i>Mocker</i>		15. MOTHER'S MAIDEN NAME First <i>Kathryn</i> Middle <i>Bachman</i> Last <i>Bachman</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>220-46-2288</i>		17 INFORMANT <i>Mr. Carl H. Franz</i>		Address <i>Hagerstown, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure</i> <i>+409</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalised Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 wk</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Thrombophlebitis Rt leg</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>11/21</i> , 19 <i>62</i> , to <i>5/10</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>5/5</i> , 19 <i>68</i> , and that in <i>(my)</i> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Robert H Campbell</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>5/10/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>ROBERT CAMPBELL</i>				22e. ADDRESS <i>HAGERSTOWN Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>May 13, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Hagerstown-Washington Md.</i>	
24. FUNERAL DIRECTOR <i>Wm. C. Horst</i>				ADDRESS <i>Rest Haven Funeral Chapel Hagerstown, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>MAY 13 1968</i>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



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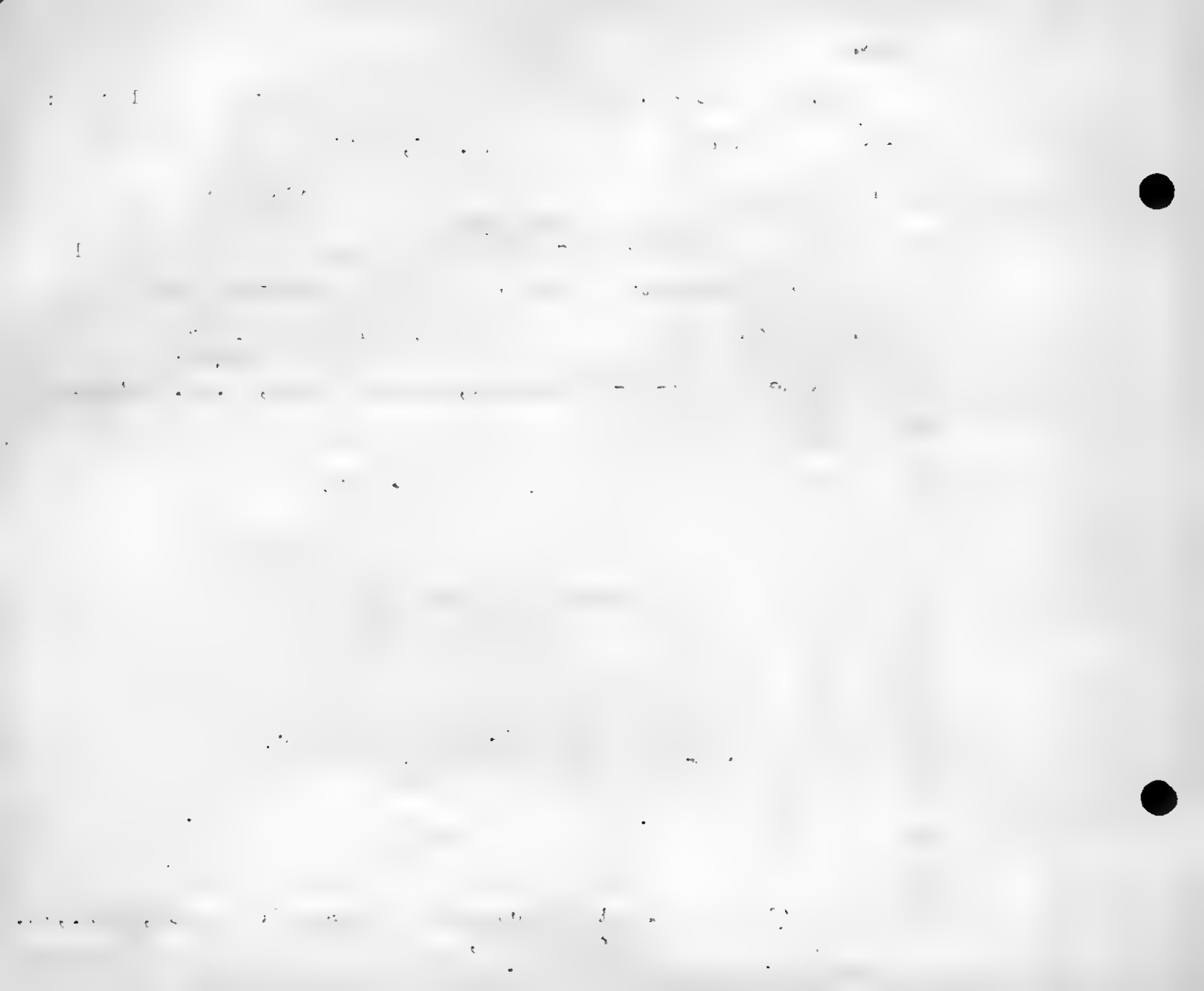
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VR A-1
30M REV. 1-66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

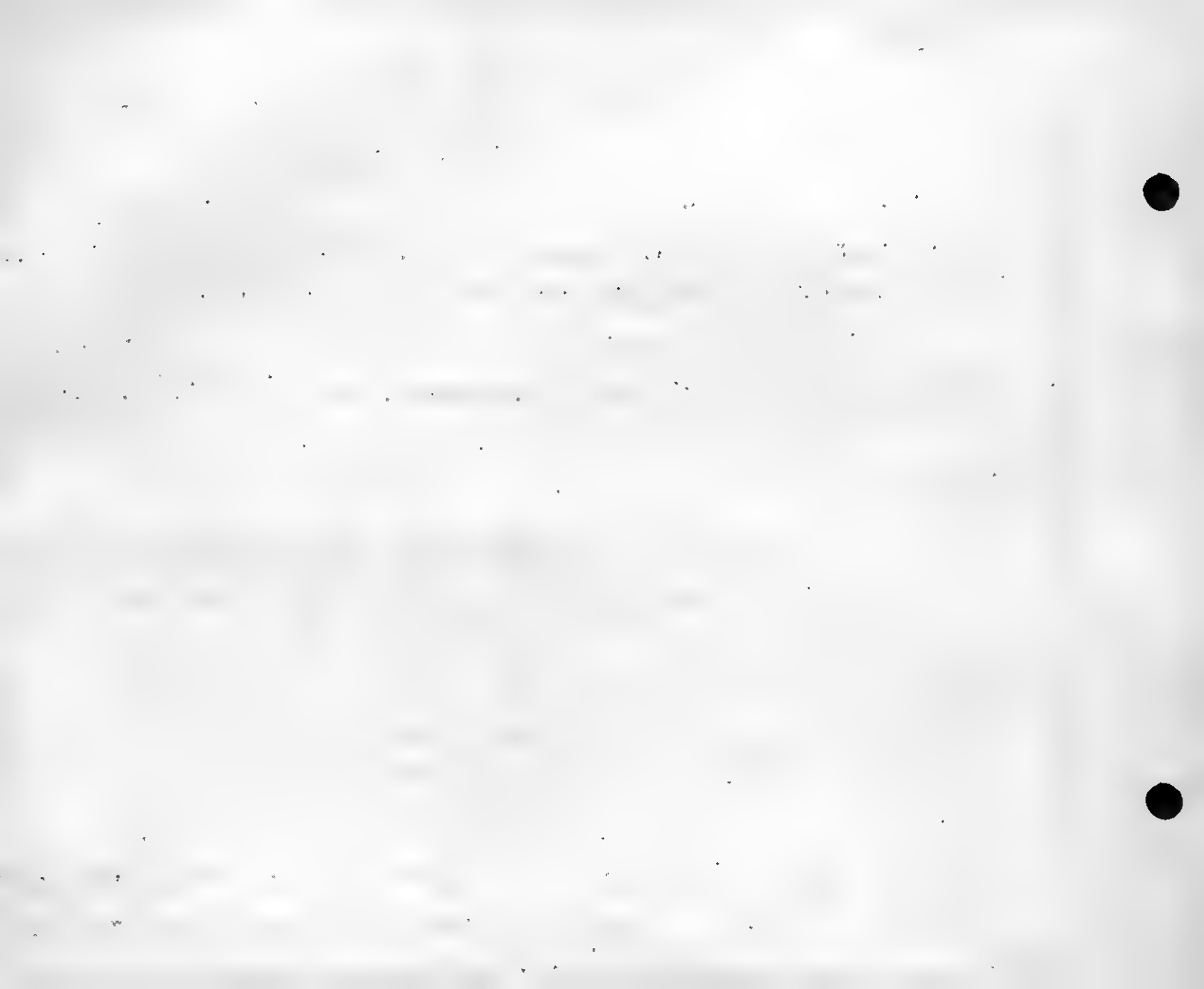
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) ETHEL ELIZABETH GAY			2a. DATE OF DEATH Month May Day 5 Year 1968		2b. HOUR 8:30A
3. SEX Female	4 RACE White	5. DATE OF BIRTH Aug. 15, 1923		6. AGE (In years lost birthday) 44 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington	
10. CITY OR TOWN OF DEATH Dargan		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Shinham Residence- Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Cook	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Dargan	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Shinham Road			
14. FATHER'S NAME First Middle Last Raymond Lawrence Gay			15. MOTHER'S MAIDEN NAME First Middle Last Annie Elizabeth Hetzel		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. 217-12-2181		17. INFORMANT Miss Betty Ann Hambleton	
				RFD#1, Harpers Ferry, W.Va. 25425	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis - DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos. 10 yrs.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from May 5, 1968 , to May 5, 1968 , that (I) (we) last saw the deceased alive on May 5, 1968 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.					
22b. SIGNATURE G.W. Livan M.D.		22c. DATE SIGNED May 7, 1968		22d. PHYSICIAN'S NAME (Type) G.W. Livan M.D.	
22e. ADDRESS Boonsboro, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/8/68		23c. NAME OF CEMETERY OR CREMATORY Samples Manor Cemetery	
23d. LOCATION (City or Town) (County) (State) Samples Manor, Wash., Md.					
24. FUNERAL DIRECTOR Donald Zackles		25a. REC'D BY REGISTRAR MAY 8 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) ELLEN			First Middle Lost VIRGINIA			2a. DATE OF DEATH Month Day Year 5 / 3 / 68			2b. HOUR 1:00
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MARCH 5, 1894		6. AGE (In years lost birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON			
10. CITY OR TOWN OF DEATH HAGERSTOWN			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 34 LAUREL STREET			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED SALESLADY		12b. KIND OF BUSINESS OR INDUSTRY CLOTHING STORE	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY WASHINGTON		13c. CITY OR TOWN HAGERSTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 34 LAUREL STREET	
14. FATHER'S NAME First Middle Lost WILLIAM			15. MOTHER'S MAIDEN NAME First Middle Lost NANNIE			NICHOLS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO 219-20-2107		17. INFORMANT GIBBS ROAD, SPRINGWATER, N.Y. 14560				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Rheumatoid Arthritis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the physician) attended the deceased from Oct 1953 to 1964 , that (I) (we) lost saw the deceased alive on April 2 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Lloyd A. Hoffman					DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/6/68
22d. PHYSICIAN'S NAME (Type) LLOYD A. HOFFMAN, M.D.					22e. ADDRESS 214 N. POTOMAC ST. HAGERSTOWN, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5/7/68		23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD.			
24. FUNERAL DIRECTOR L. Eichelberger				ROUZER FUNERAL HOME HAGERSTOWN, MARYLAND		25a. REC'D BY REGISTRAR May 8 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



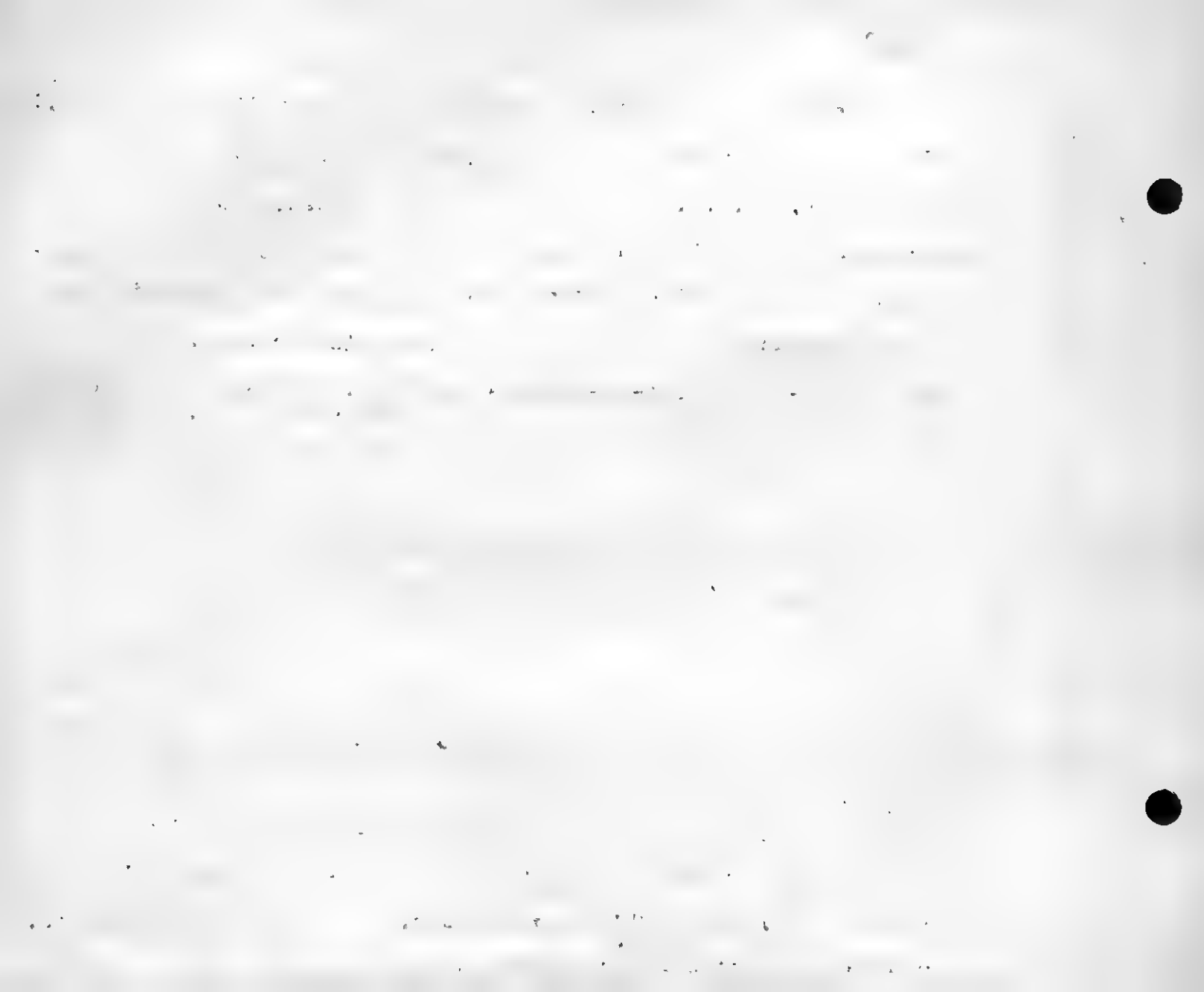
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VR A13
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) PETER EDWARD GOODMAN			2a. DATE OF DEATH Month Day Year May 12 1968			2b. HOUR 9.20^{PM}			
3 SEX Male		4 RACE White		5. DATE OF BIRTH April 24 1897		6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS M.IN.	
7a. BIRTHPLACE (State or foreign country) New York City		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Avalon Manor		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Merchant		12b. KIND OF BUSINESS OR INDUSTRY Store			
13a. USJA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 2021 Virginia Ave	
14. FATHER'S NAME First Middle Last Emil Goodman			15. MOTHER'S MAIDEN NAME First Middle Last Katherine Schwartz						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. A 214-01-8204		17 INFORMANT Mrs Esther S. Goodman		Address 2021 Virginia Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Fibrosis DUE TO, OR AS A CONSEQUENCE OF (b) (Harrison-Rich Syndrome) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 525X DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3mo									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Chronic bronchitis & lymphocoma									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from April, 1963 to May, 1968 , that (I) (we) last saw the deceased alive on May 11, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Charles C. Spencer				DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 5/13/68	
22d. PHYSICIAN'S NAME (Type) Charles C. Spencer M.D.				22e. ADDRESS 145 S. Prospect St. Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/15/68		23c. NAME OF CEMETERY OR CREMATORY B'nai Abraham Cem.		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md.			
24. FUNERAL DIRECTOR Andrew K. Coffman				FIRM Funeral Home Inc		25a. REC'D BY REGISTRAR MAY 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



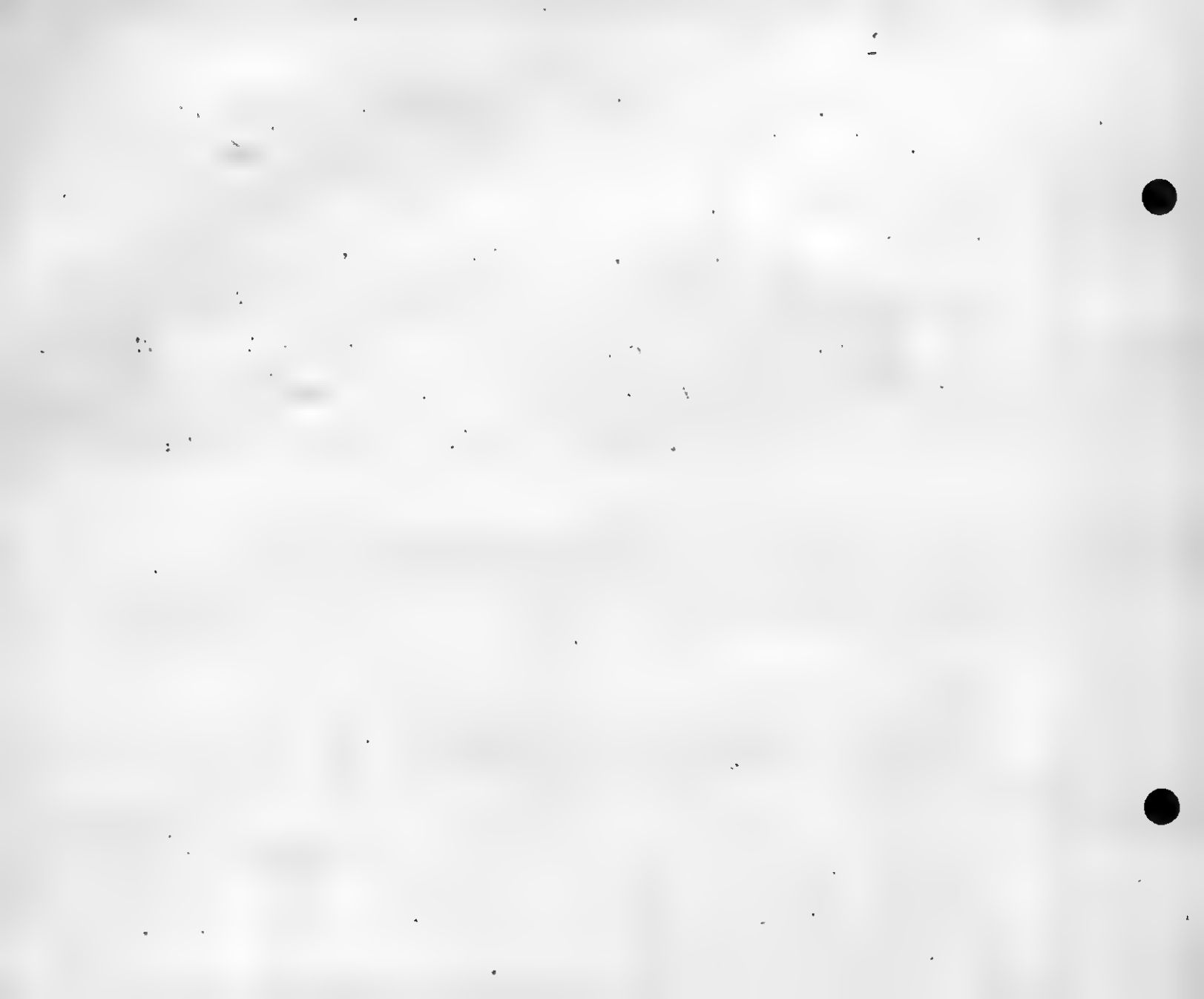
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15-14
304, REV. 1-68

CERTIFICATE OF DEATH

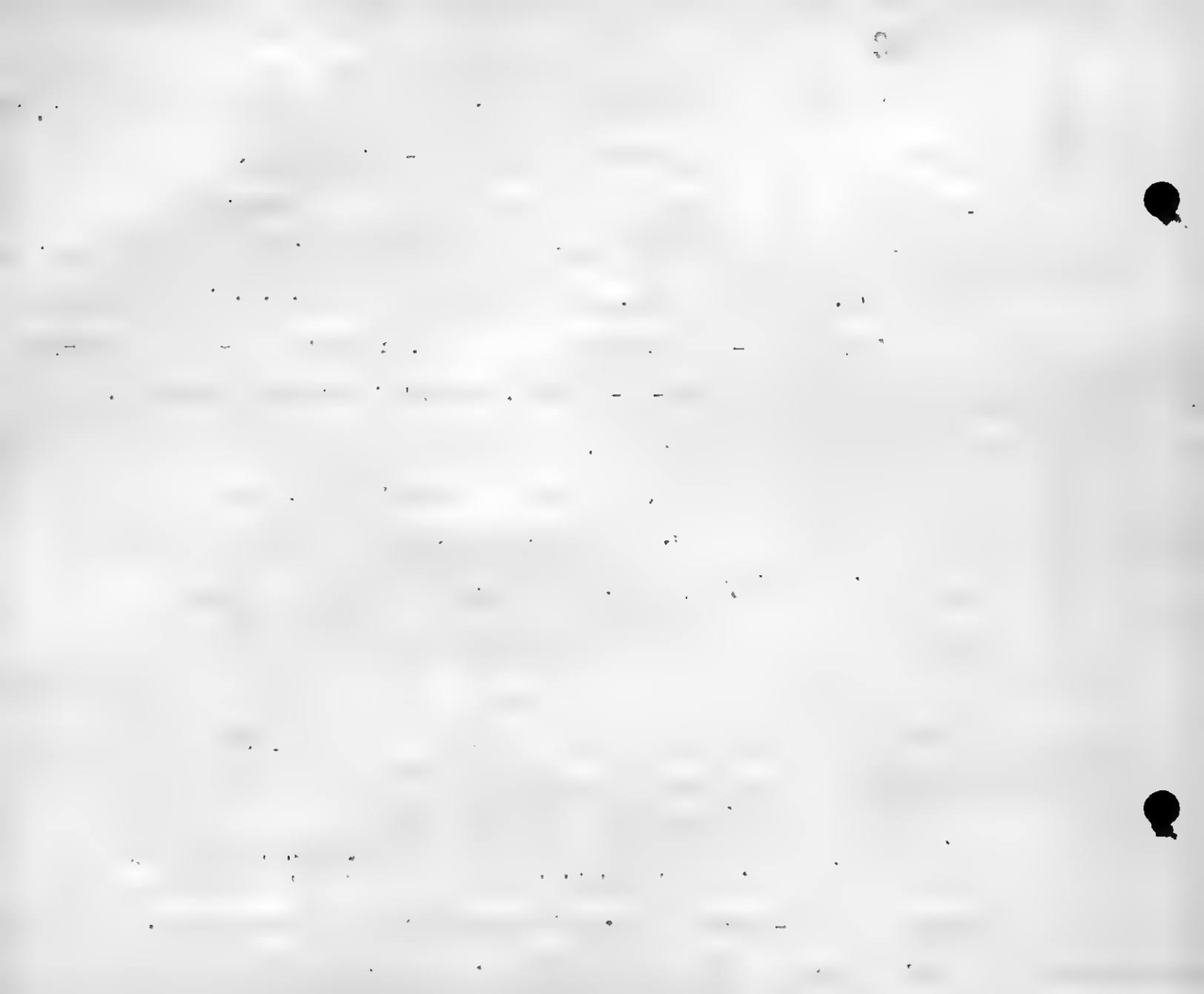
1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month		Day	Year	2b. HOUR
JOSEPH		WILLIAM	GRIFFITH	MAY	19	1968	6	25	PM
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.
MALE	WHITE		11-29-1901		68 YRS.		MONTHS		DAYS
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		U.S.				WASHINGTON			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
HAGERSTOWN		WESTERN MD. STATE HOSPITAL		CUTTER		SHOE MFG			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		Washington						220 Rosemar Ave.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT	
JOSEPH		B. GRIFFITH		VIRGINIA		ASHWOOD		Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the rectum with metastasis</u>		Feb 6 1968		Exploratory Laparotomy		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year				While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
22a. I certify that (I) (this hospital) attended the deceased from <u>March 13, 1968</u> to <u>May 19, 1968</u> , that (I) (we) last saw the deceased alive on <u>May 18, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS	
		FE U. Porciani		5/19/68		FE U. Porciani		1500 Pennsylvania Ave.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		24. FUNERAL DIRECTOR	
Burial		5-22-68		Rest Haven Cemetery		Hagerstown, Md.		Minnich Funeral Home Hagerstown, Md.	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE		25d. REGISTRAR'S SIGNATURE		25e. DATE	
		Charles J. Juge		MAY 21 1968					



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR				
James Walter Grimm						May 3, 1968			10:20				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (in years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS M.N.		
male		white		2-25-1888			80 YRS.						
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.	
Maryland			USA						Washington				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Hagerstown			Avalon Manor			Machinist			Refrigeration				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER	
Md.			Wash.			Hagerstown			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			R.F.D.#6	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
First Middle Last			First Middle Last										
Douglas - Grimm			Margaret - Kidwiler										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address				
no			212-14-6552			Mr. Harold Grimm			Hagerstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>										30 Min.			
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost													
(b) <u>Patent Sclerotic Heart Disease</u>										30 yr			
DUE TO, OR AS A CONSEQUENCE OF													
(c) <u>Senile Arteriosclerosis</u>										50 yr			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
<u>Prostate Hypertrophy, Benign</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from <u>4-20</u> , 19 <u>68</u> , to <u>5-5</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>5-5</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED					
<u>Edward W. Ditto III</u>								<u>5-6-68</u>					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS											
Edward W. Ditto, III, M.D.		217 W. Washington Street Hagerstown, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)			
Burial		5-8-1968		Rose Hill Cemetery		Hagerstown, Md.							
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Minnich Funeral Home		Hagerstown, Md.		MAY 9 1968		<u>Charles Judge</u>							



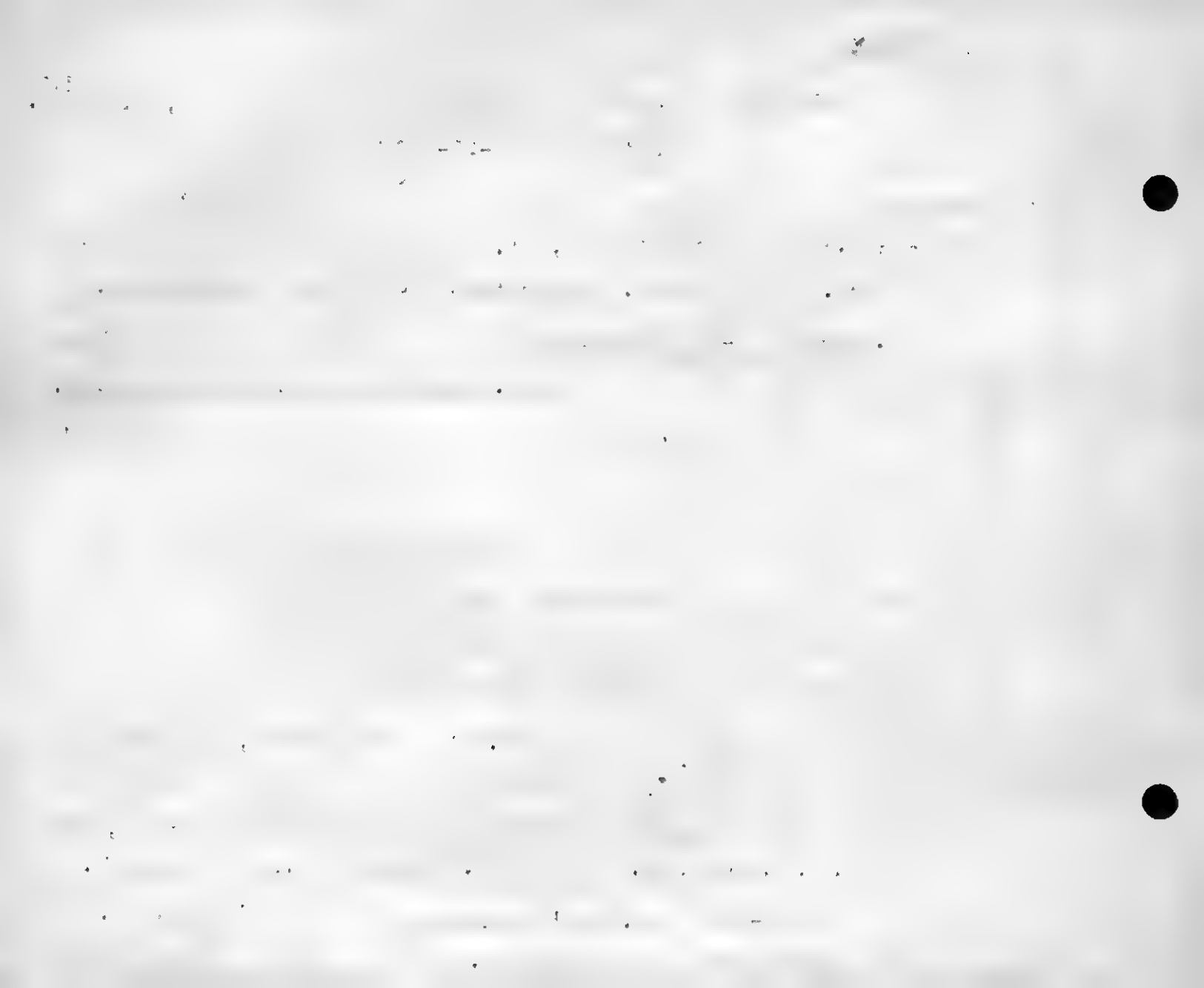
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Ralph Cecil Guessford			2a. DATE OF DEATH Month May Day 8 Year 1968			2b. HOUR 1:30 P. M.	
3 SEX male		4. RACE white		5. DATE OF BIRTH 6-29-1918		6. AGE (In years last birthday) 49 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.	
10 CITY OR TOWN OF DEATH Hagerstown		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 351 Liberty, St.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) none		12b. KIND OF BUSINESS OR INDUSTRY none	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Wash.		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 351 Liberty, St.							
14. FATHER'S NAME First Edward Middle - Last Guessford			15 MOTHER'S MAIDEN NAME First Lillie Middle - Last Higgins				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Mary Hildebrand Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis 186 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 day's							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Apr. 29, 1968 , to May 8, 1968 , that (I) (we) last saw the deceased alive on May 2, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>E. W. Ditto</i>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED May 10, 1968			
22d. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.		22e. ADDRESS 215 W. Washington St., Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-11-1968		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		23d. LOCATION (City or Town) (County) (State) Clear Spring, Md.	
24 FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 13 1968		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

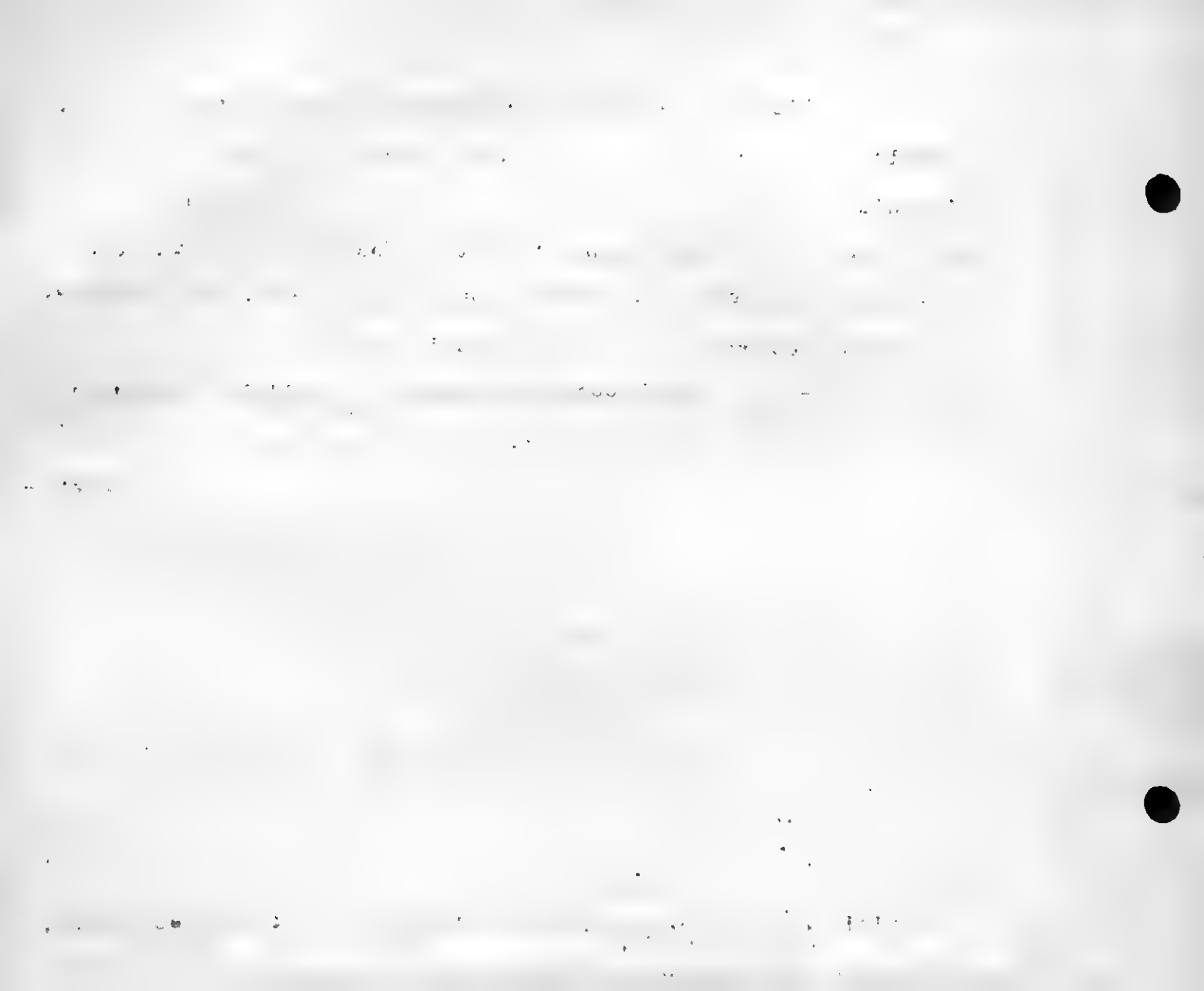


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year			2b. HOUR P M		
WILDA PAULINE GUESSFORD						May 24 1968			3.20 P		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
Female		White		Aug 1 1905			62 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Virginia		USA				Washington Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown			Wash County Hospital			Housewife			Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Washington			Hagerstown				614 W. Washington St	
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost
Aaron Godlove						Mamie Smith					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
No			No Record			Mrs Bernal F. Leasure			140 Penna Ave		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						Warren Ohio			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY.											
IMMEDIATE CAUSE (a)						Bronchopneumonia			2 day		
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						(b) Hepatic failure			(see) hypox		
DUE TO, OR AS A CONSEQUENCE OF						(c) Cirrhosis			1-2 yr		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No			City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from Nov 28, 1961, to 5/24, 1968, that (I) (we) lost saw the deceased alive on 5/24/68 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
Robt V. H. Campbell											5/25/68
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Robt V. H. Campbell						HAGERSTOWN Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			5/27/68			Cedar Lawn Mem Gardens			Hagerstown Wash Co Md.		
24. FUNERAL DIRECTOR						Address			25a. REC'D BY REGISTRAR		
Andrew K. Coffman Funeral Home Inc						Hagerstown Md.			MAY 28 1968		
						25b. REGISTRAR'S SIGNATURE					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

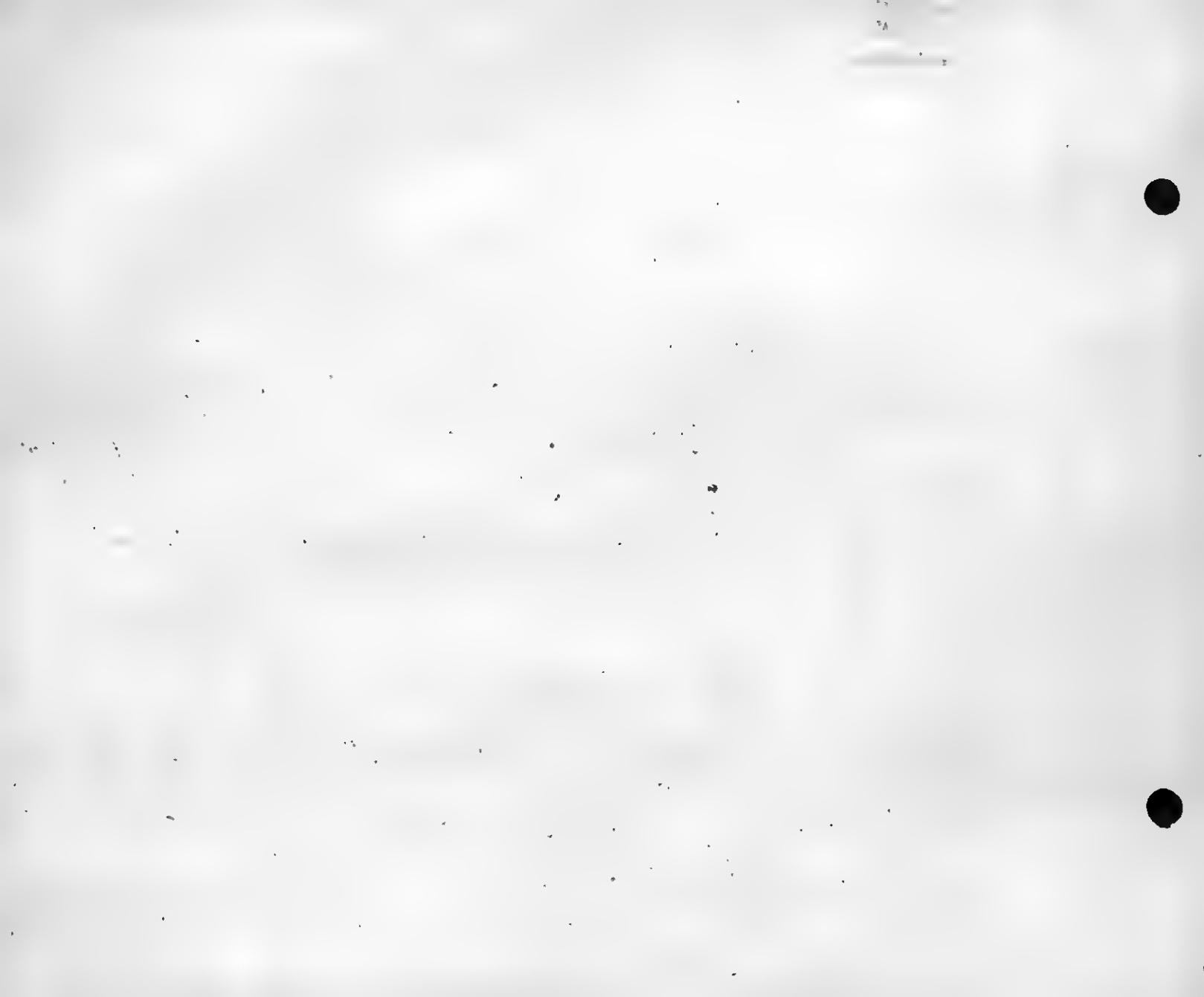
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VR 153/4
30M REV. 1/78

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Baby Boy		First Guillard		Middle		Last		2a DATE OF DEATH Month 5 Day 26 Year 1968			2b HOUR 9 45 PM		
3 SEX Male		4 RACE White		5 DATE OF BIRTH 5-26-68			6 AGE (In years last birthday) YRS. MONTHS DAYS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Washington County Md						
10 CITY OR TOWN OF DEATH Hagerstown			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b COUNTY Washington			13c CITY OR TOWN Williamsport			13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e STREET AND NUMBER 2459 Virginia Avenue	
14 FATHER'S NAME First HA. OLD Middle GUILLARD Last			15 MOTHER'S MAIDEN NAME First SHIRLEY Middle BYERS Last										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT E. GROVE AND HAROLD GUILLARD WILLIAMSPORT, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatal Bronchitis due to DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Unresolved lung DUE TO, OR AS A CONSEQUENCE OF (c) Protrusio - Cystic Hypertrophy of the Neck Muscles										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hrs 45 min Some Some			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM, STREET FACTORY) OFFICE BUILDING, ETC.		21f LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from 5/26/68, 1968 to 5/26/1968 , that (I) (we) saw the deceased alive on 5/26/68 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE A. M. Bacon MD				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 5/27/68					
22d. PHYSICIAN'S NAME (Type) A.M. BACON, JR., M.D.				22e ADDRESS 101 KING ST HAGERSTOWN, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5/28/68		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY				23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASHINGTON CO., MD.					
24 FUNERAL DIRECTOR William J. Kasper				ADDRESS HAGERSTOWN, MARYLAND				25a REC'D BY REGISTRAR DATE MAY 31 1968		25b REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

87632

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

87656

1 DECEASED-NAME (Type or print) Robert Alexander Hamil			2a. DATE OF DEATH 5 Month 30 Day 68 Year			2b. HOUR 4:30 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 2/24/97		6. AGE (In years lost birthday) 71 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Foltz, Pa		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Co. Hagerstown Md.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Restaurant operator & owner		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased admission) STATE Penna.		13b. COUNTY Fulton		13c. CITY OR TOWN Mc Connellsburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Lincoln Way East	
14. FATHER'S NAME First Middle Last Harry Not Known Hamil			15. MOTHER'S MAIDEN NAME First Middle Last Alice Vance Hamil						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) Yes		16b. SOCIAL SECURITY NO (If yes give war or dates of service) WWII 363-26-4365		17. INFORMANT Patient		Mc Connellsburg, Pa			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Myelogenous Leukemia</u> 2050 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 2043 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4-6	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Acute Perforating Pharyngitis due to Paracoccus & Pericarditis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>May 24, 1968</u> , to <u>May 30, 1968</u> , that (I) (we) last saw the deceased alive on <u>May 30, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Edson B. Moody</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/31/68			
22d. PHYSICIAN'S NAME (Type) Edson B. Moody, M.D.				22e. ADDRESS 363 S. Cleveland Ave. Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 1, 68		23c. NAME OF CEMETERY OR CREMATORY Union		23d. LOCATION (City or Town) (County) (State) Ayr Twp. Fulton Co. Pa			
24. FUNERAL DIRECTOR F.M. Lininger, Mc Connellsburg, Pa				25a. REC'D BY REGISTRAR DATE JUN 3 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

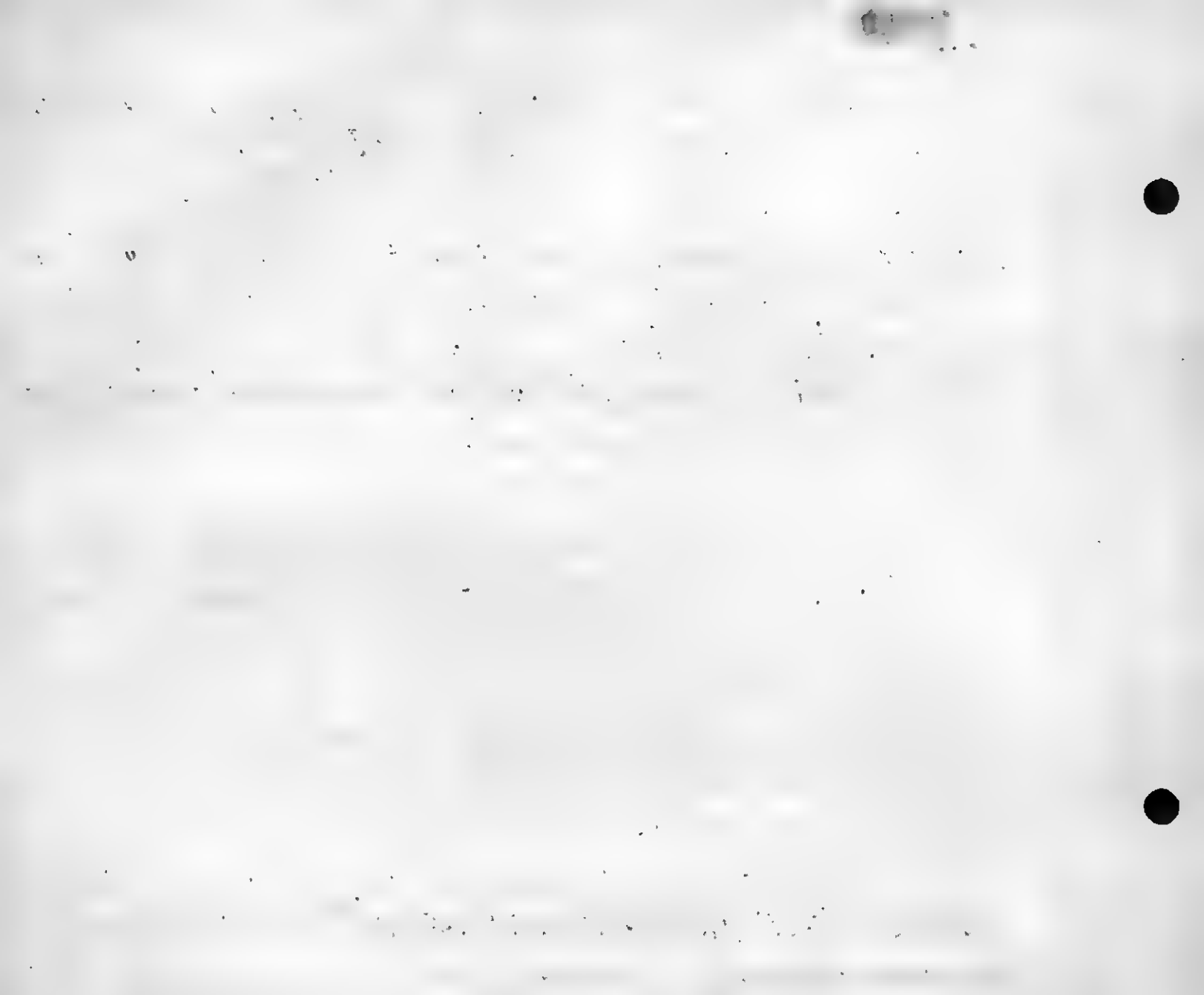
VR 15-1
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01051

1. DECEASED NAME (Type or print) First Middle Last <i>Jerry W. Hare</i>			2a. DATE OF DEATH Month Day Year <i>May 22, 1968</i>			2b. HOUR <i>12:20 P.</i>					
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>June 3, 1897</i>		AGE (In years last birthday) <i>70</i>		6. UNDER YEAR MONTHS DAYS <i>YRS.</i>		7. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Washington</i>					
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington County Hosp.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Farmer</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Own Farm</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>			13b. CITY OR TOWN <i>Washington</i>			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13d. STREET AND NUMBER <i>R. D. 1 25425</i>		
14. FATHER'S NAME First Middle Last <i>Augustus Hare</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Susie Hare</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give branch and dates of service) <i>Yes WWI-3</i>			16b. SOCIAL SECURITY NO. <i>100-12-9388</i>			17. INFORMANT <i>Mrs. Myrtle Hare, Harpers Ferry, W. Va. R.D. 1</i>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>multiple myeloma</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>fairly recent myocardial infarction</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>May 21, 1968</i> , to <i>May 22, 1968</i> , that (I) (we) lost the deceased on <i>May 21, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>R. Amarillo</i>			DEGREE <i>M.D.</i>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>5/22/68</i>		
22d. PHYSICIAN'S NAME (Type) <i>R. Amarillo</i>			22e. ADDRESS <i>Sharpsburg Md 21782</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>May 25, 1968</i>			23c. NAME OF CEMETERY OR CREMATOR <i>Middletown Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Freeland, Balto, Md.</i>		
24. FUNERAL DIRECTOR <i>James Hartenstein, New Freedom, Pa.</i>			25a. RECEIVED BY REGISTRAR <i>May 28 1968</i>			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			DATE		



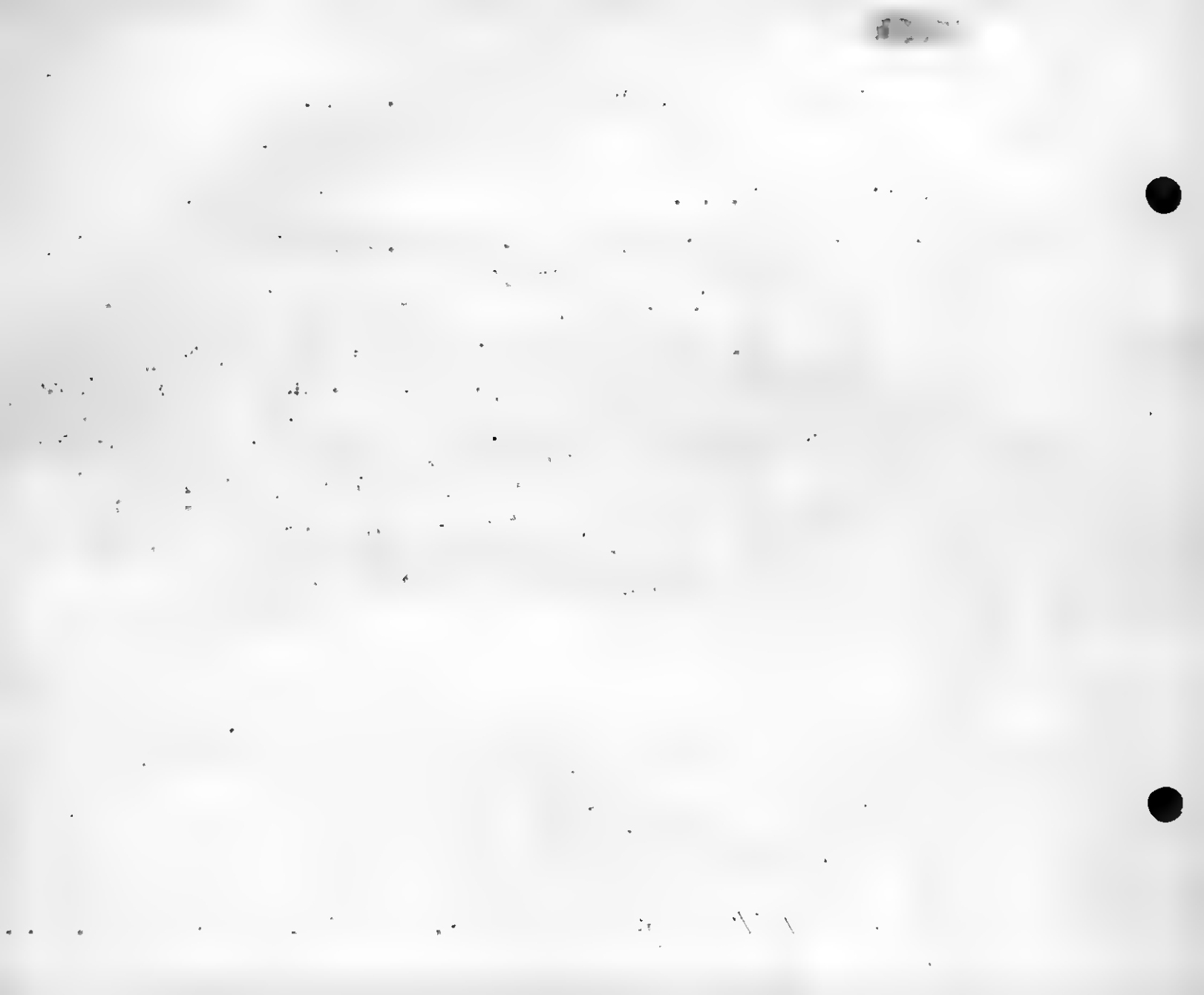
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
30M REV 1-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) FRANCIS MILTON HECK SR.			2a DATE OF DEATH MAY Month 23 Day 1968		2b HOUR 8:35A
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 12/14/1898		6. AGE (In years last birthday) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Md.	
10. CITY OR TOWN OF DEATH HAGERSTOWN	11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) WESTERN MD. STATE HOSP.	12a. USUAL OCCUPATION (Kind of work done during last year) RETIRED SUPERVISOR	12b. KIND OF BUSINESS OR INDUSTRY POST OFFICE		
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE MARYLAND	13b. COUNTY WASHINGTON	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 22 MOLIER PKWY.		
14. FATHER'S NAME First Middle Last JOHN F. HECK		15. MOTHER'S MAIDEN NAME First Middle Last MOLLIE CATHERINE BOYER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address MRS. MYRTLE L. HECK HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 2509 DUE TO, OR AS A CONSEQUENCE OF Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Diabetes mellitus (b) years (c) 1					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24hr
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) lobular pneumonia					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 5-15 , 19 68 , to 5-23 , 19 68 , that (I) (we) lost the deceased alive on 5-22 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Edwin G. Riley		DEGREE MD	ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22c. DATE SIGNED 5-23-68	
22d. PHYSICIAN'S NAME (Type) Edwin G. Riley		22e. ADDRESS 1500 Penna Hagerstown, Md			
23a. BURIAL, CREMATION, or other disposition BURIAL	23b. DATE 5/26/68	23c. NAME OF CEMETERY OR CREMATORY BEST HAVEN CEM.	23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.		
24. FUNERAL DIRECTOR W. J. Korman		ADDRESS Hagerstown, Md.	25a. REC'D BY REGISTRAR MAI 27 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	



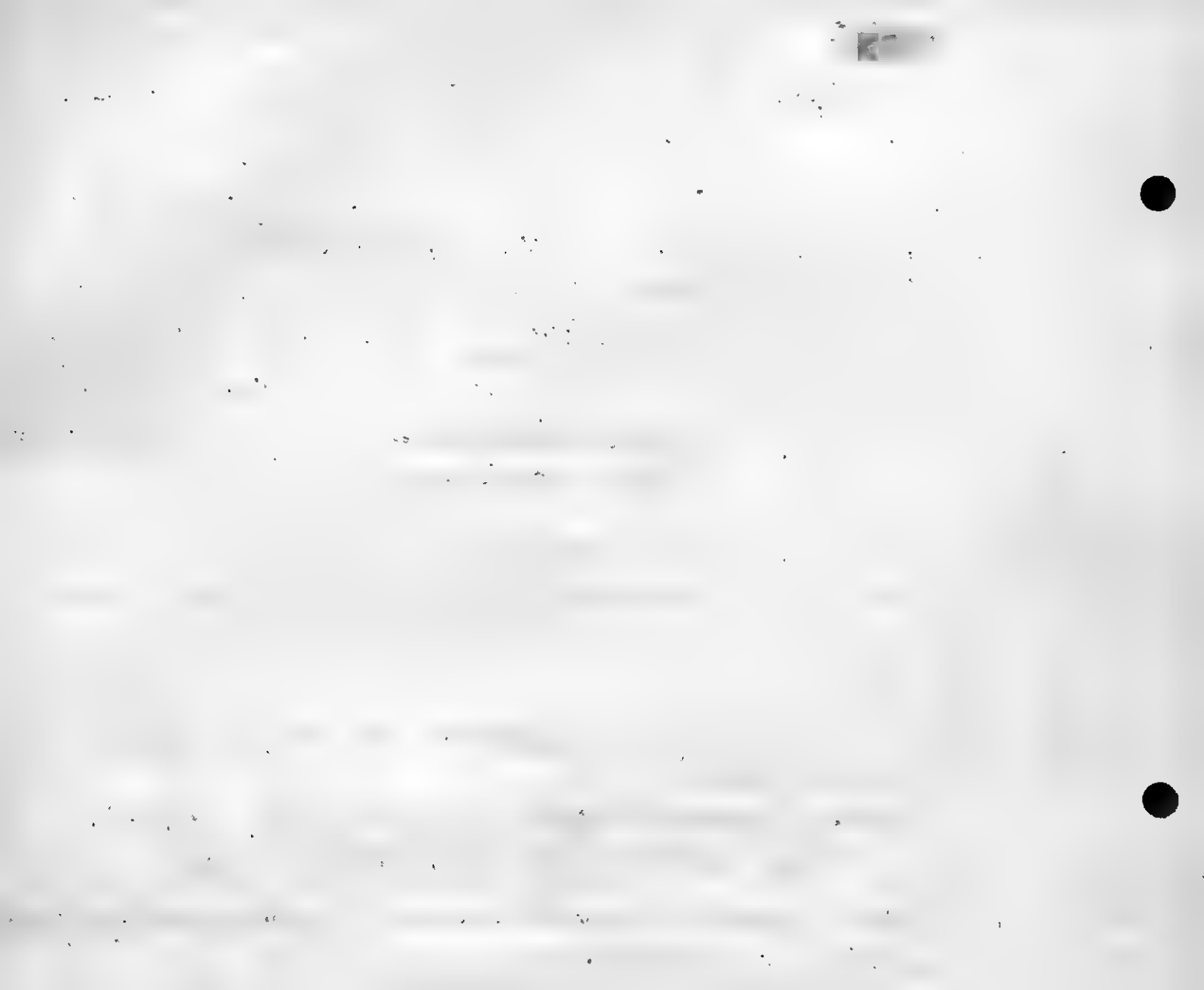
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

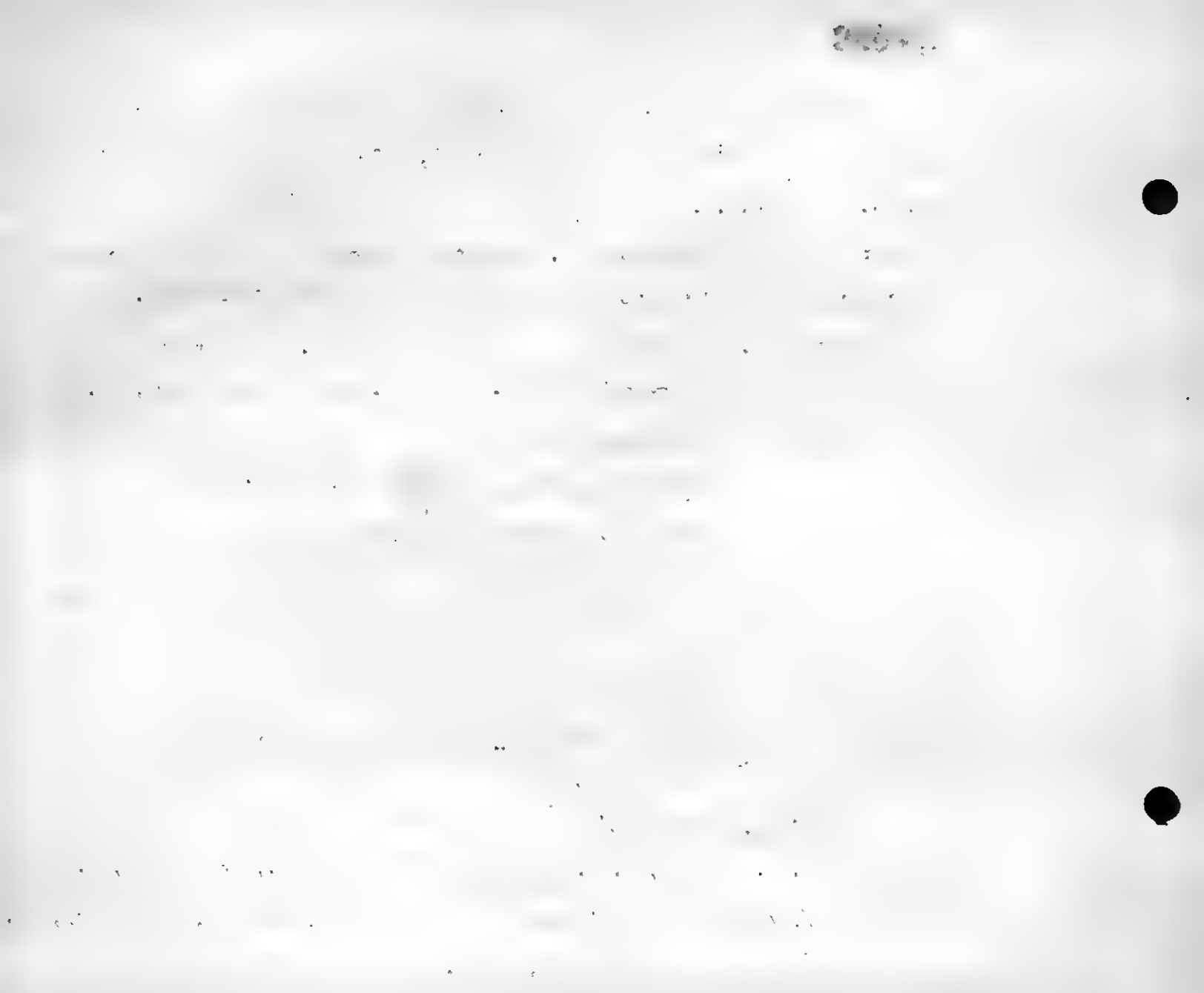
1 DECEASED-NAME (Type or print) Emma		First	Middle	Last	2a. DATE OF DEATH Month Day 9 Year 68		2b. HOUR 9 P. M.
3 SEX Female		4 RACE White		5 DATE OF BIRTH March 24, 1886		6 AGE (In years last birthday) 82 YRS.	
7a BIRTHPLACE (State or foreign country) Huntington Co.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Washington County Md.	
10 CITY OR TOWN OF DEATH Williamsport		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Williamsport Sanitarium		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Store clerk		12b KIND OF BUSINESS OR INDUSTRY	
13a USJAL RESIDENCE (Where deceased lived, if institution Residence before admission) Pennsylvania		13b COUNTY Franklin		13c CITY OR TOWN Waynesboro		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 17 N Brant Street		14. FATHER'S NAME First Middle Last James Anderson		15. MOTHER'S MAIDEN NAME First Middle Last Rebecca Johnson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) No	
16b SOCIAL SECURITY NO. 202-20-6132		17. INFORMANT Mrs Phyllis Smith 322 Commerce St PA.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 1557 DUE TO, OR AS A CONSEQUENCE OF (b) Arterio sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yr 2 months			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from March 10, 1965, to May 9, 1968, that (I) (we) last saw the deceased alive on May 9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE Sidney Novenstein MD		22c. DATE SIGNED 5-10-68		22d. PHYSICIAN'S NAME (Type) SIDNEY NOVENSTEIN		22e. ADDRESS FUNKSTOWN MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 5/15/1968		23c NAME OF CEMETERY OR CREMATORY Green Hill Cemetery		23d LOCATION (City or Town) (County) (State) Waynesboro Franklin Penna.	
24. FUNERAL DIRECTOR S. Marlin Roe		ADDRESS Waynesboro, Penna.		25a. REC'D BY REGISTRAR DATE MAY 15 1968		25b REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First Joseph		Middle H.		Last Hess.		2a. DATE OF DEATH Month May Day 19 Year 1968		2b. HOUR 7:10 A.M.	
3 SEX Male		4 RACE White		5 DATE OF BIRTH April 3, 1920			6. AGE (In years last birthday) 48 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington			Md.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Teacher			12b. KIND OF BUSINESS OR INDUSTRY Education				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 228 Belview Ave.			
14 FATHER'S NAME First Herman Middle O. Last Hess			15. MOTHER'S MAIDEN NAME First Iva Middle V. Last Kipe									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 203-10-4401		17 INFORMANT Mrs. Joseph H. Hess			Address Hagerstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Essential Hypertension (b) Essential Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) Unknown Cause.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 444												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 8-27 , 19 67 , to 5-18- , 19 68 , that (I) (we) last saw the deceased alive on 5-18-68 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE E. E. Rosillo					DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5-20-68			
22d. PHYSICIAN'S NAME (Type) E. E. Rosillo M.D.					22e. ADDRESS 580 Northern Ave., Hagerstown, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5/22/1968		23c. NAME OF CEMETERY OR CREMATORY Ringgold			23d. LOCATION (City or Town) (County) (State) Hagerstown #5, Washington, Md.					
24. FUNERAL DIRECTOR Walter G. Gove					ADDRESS Waynesboro, Penna.		25a. REC'D BY REGISTRAR DATE MAY 24 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

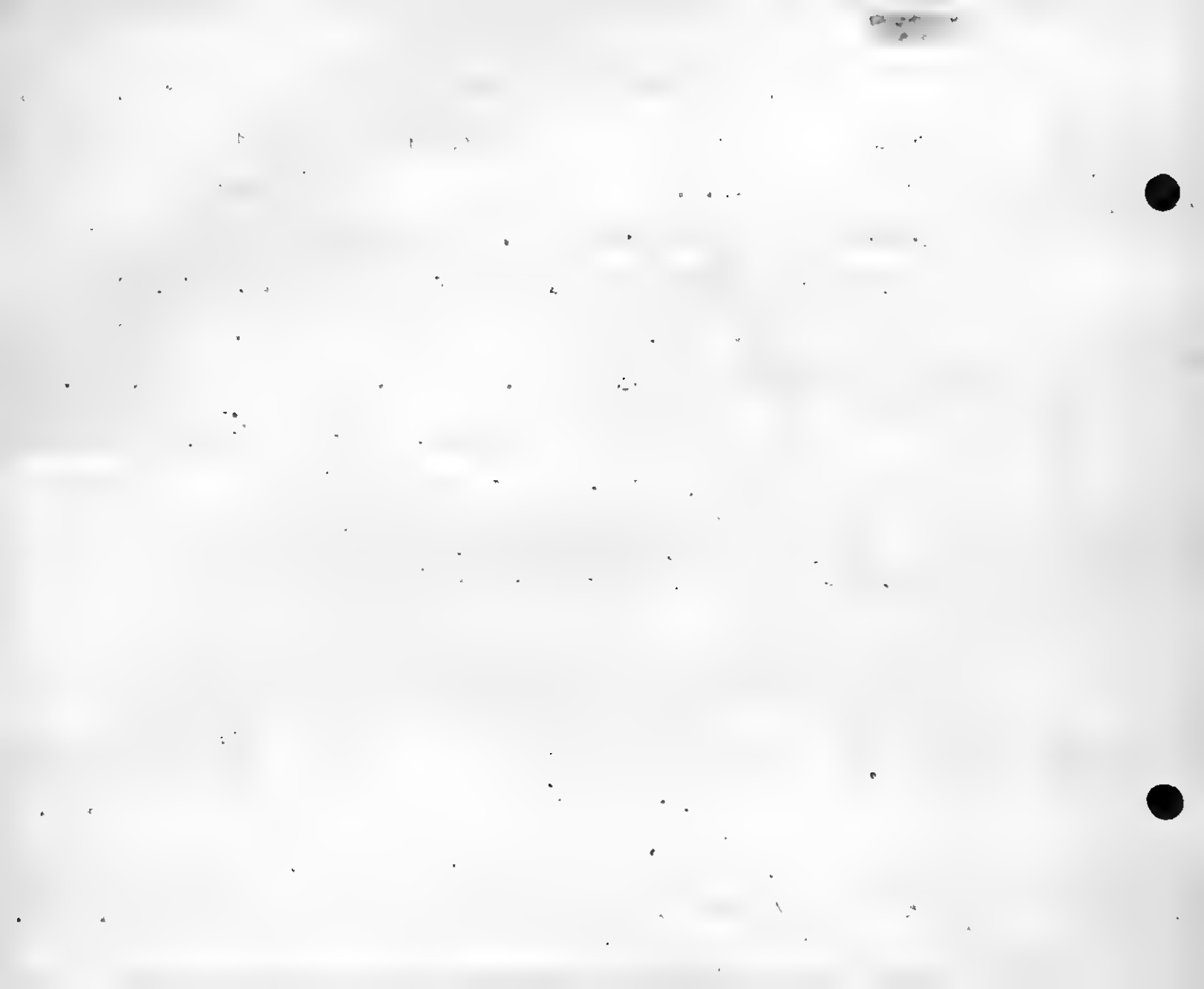


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

X

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) First GERTRUDE Middle SOPHIA Last HORST					2a. DATE OF DEATH May Month 8 Day 1968			2b. HOUR 4 P. M.		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 7/21/1886		6. AGE (in years last birthday) 81 YRS.		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Md.				
10. CITY OR TOWN OF DEATH HAGERSTOWN			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5 W. LONGMEADOW RD.			12a. USUAL OCCUPATION (Kind of work done during most of last year, or if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND			13b. CITY OR TOWN WASHINGTON		13c. CITY OR TOWN HAGERSTOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 5 W. LONGMEADOW RD.	
14. FATHER'S NAME First Middle Last JOHN E. GEHR				15. MOTHER'S MAIDEN NAME First Middle Last MARY A. COOK						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> NO (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO NONE		17. INFORMANT Address MR. ABRAM S. HORST HAGERSTOWN MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary artery dis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic cardiac dis.</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day years 11	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes</u> <u>Previous Myocardial infarction</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>10 Feb</u> , 19 <u>68</u> to <u>date</u> , that (I) (we) last saw the deceased alive on <u>6 May</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Richard T. Binford</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10 Feb. 68				
22d. PHYSICIAN'S NAME (Type) Richard T. Binford, M. D.				22e. ADDRESS 1135 Potomac Avenue Hagerstown, Md.						
23a. BURIAL, CREMATION, OR OTHER DISPOSAL Burial		23b. DATE 5/11/68		23c. NAME OF CEMETERY OR CREMATORY CLEARSRING MENNONITE		23d. LOCATION (City or Town) (County) (State) CLEARSRING WASH. MD.				
24. FUNERAL DIRECTOR <u>U.S. Monument Hagerstown, Md</u>				ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 15 1968		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

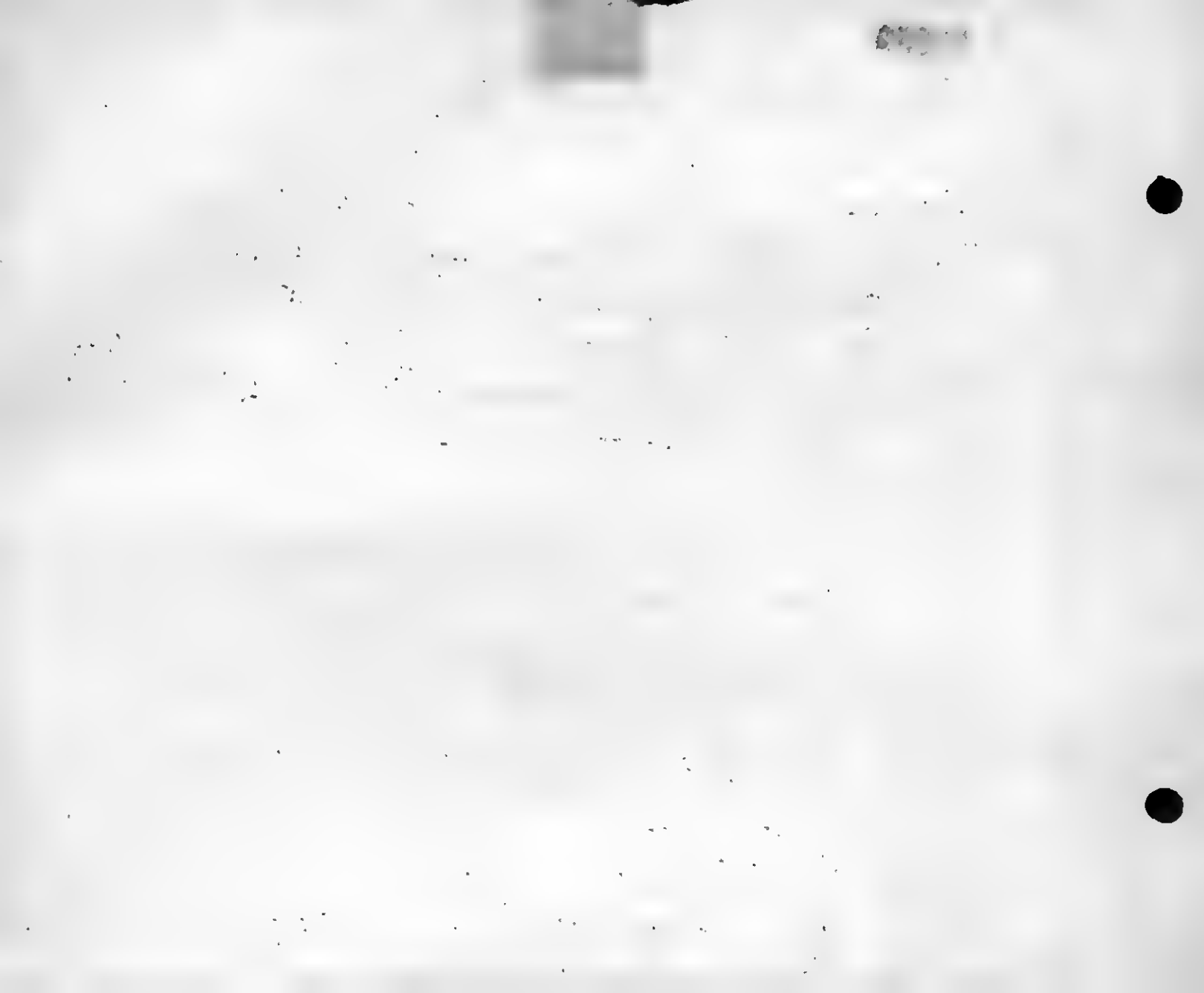
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) Paul C. Jewell					2a. DATE OF DEATH Month May Day 14 Year 1968		2b. HOUR 9:10 AM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MAY 26, 1901		6. AGE (In years last birthday) 66 YRS.		IF UNDER YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON			
1d. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) C. A. Worker		12b. KIND OF BUSINESS OR INDUSTRY Celanese			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER HOMEWOOD ADDITION	
14. FATHER'S NAME First Middle Last CHARLES E. JEWELL				15. MOTHER'S MAIDEN NAME First Middle Last SARAH CLINE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no. or unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 217 10 5182		17. INFORMANT Homewood Addition Mrs. Evelyn Jewell Cumberland, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia DUE TO, OR AS A CONSEQUENCE OF Carcinoma of lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk 6 mon									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 163x Pyelonephritis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. ex. examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from 5-8 , 19 68 , to 5-14 , 19 68 , that (I) (we) last saw the deceased alive on 5-13 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Edwin G. Riley				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 5-14-68			
22d. PHYSICIAN'S NAME (Type) Edwin G. Riley				22e. ADDRESS 1500 Penna, Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5/1/68		23c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) Cumberland, Md.			
24. FUNERAL DIRECTOR Byron Knight				25a. REC'D BY REGISTRAR DATE MAY 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

The first part of the document
 describes the general situation
 and the results of the
 investigation. The second part
 contains the detailed description
 of the methods used in the
 study. The third part
 discusses the results of the
 study and compares them with
 the results of other studies.
 The fourth part contains the
 conclusions of the study and
 the recommendations for further
 research.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
HELEN E. JONES						Month Day Year MAY 9 1968			1:45 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
F.		W		OCT. 9-1875		92 YRS		MONTHS	DAYS	HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH					
DELAWARE		U.S.A.				WASHINGTON					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
HAZERSTOWN, Md.			WASHINGTON COUNTY			At Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
MARYLAND			WASHINGTON			HAZERSTOWN			ROUTE 2-		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last JOHN B. HERRIN			First Middle Last BETTY MOORE								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
			215-70-3510			MRS JOHN KETTER			244 WALGROVE ROAD HAZERSTOWN, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4503</u>											
(b) <u></u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u></u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
<u>Dehydration</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>April 18, 1966</u> , to <u>MAY 9, 1968</u> , that (I) (we) lost saw the deceased alive on <u>MAY 8</u> 1968, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED		
<u>Arthur M. Mandell</u>									5-9-68		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
A.M. MANDELL, M.D.			301 E. ANTIETAM ST.								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
			May 13-1968			ARRAINE CEMETERY			BALTIMORE MD.		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
<u>Arthur Waters</u>			254 CARROLL ST. N.W. WASHINGTON			DATE MAY 13 1968			<u>John Charles Judge</u>		



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MARTINBURG, MARYLAND											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) JOHN DANIEL KERN						2a. DATE OF DEATH Month May Day 6 Year 1968			2b. HOUR 6:10A M		
3 SEX M		4. RACE White		5. DATE OF BIRTH July 31, 1902			6. AGE (In years last birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Martinsburg, W. Va.		7b. CITIZEN OF WHAT COUNTRY? US		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.					
10 CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Washington County Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Manager			12b. KIND OF BUSINESS OR INDUSTRY Dept. Store		
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE W. Va.			13b. COUNTY Berkeley			13c. CITY OR TOWN Martinsburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1000 W. King St.	
14. FATHER'S NAME First Middle Last John W. T. Kern				15. MOTHER'S MAIDEN NAME First Middle Last Martha C. Barbour							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 234-01-8708			17. INFORMANT Address Mrs. Myra W. Kern-Martinsburg, West Virginia					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min. 8 months	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201 Bilateral pleural effusion											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. no. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from May 4, 1968 to May 6, 1968 , that (I) (we) lost saw the deceased alive on May 6, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>John H. Kehne M.D.</i> DEGREE						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED May 6, 1968			
22d. PHYSICIAN'S NAME (Type) JOHN H. KEHNE, M. D.						22e. ADDRESS 1229 Ravenswood Hts., Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 8, 1968		23c. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery				23d. LOCATION (City or Town) (County) (State) Martinsburg Berkeley W. Va.			
24. FUNERAL DIRECTOR <i>Howard K. Brown</i> ADDRESS Martinsburg, W. Va.						25a. REC'D BY REGISTRAR DATE MAY 8 1968		25b. REGISTRAR'S SIGNATURE <i>Richard J. Jones</i>			



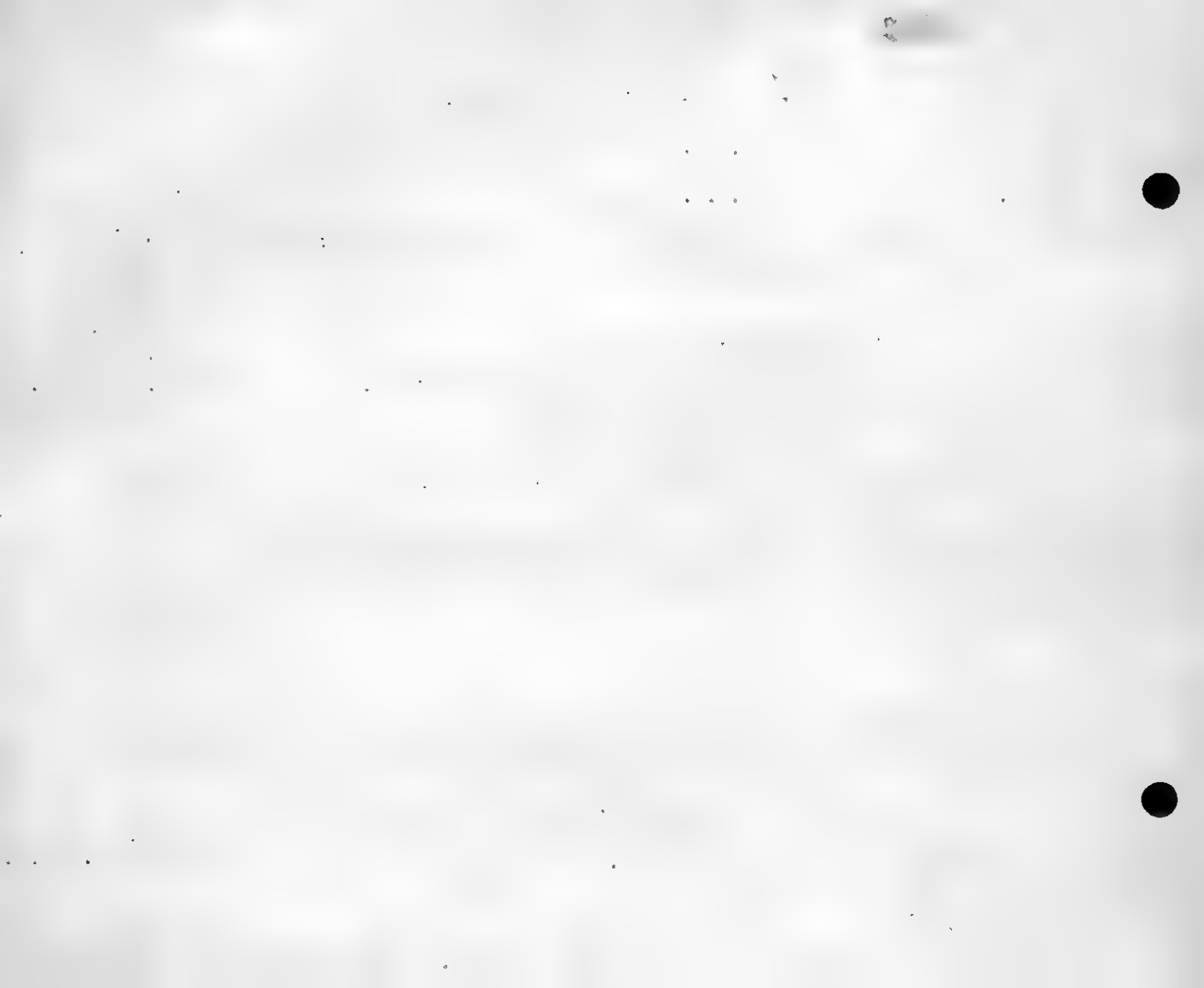
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
10M REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
KENNETH ERNEST KLINE SR.						DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 5/18/68 19			11:15		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER 24 HRS		8 IF UNDER 24 HRS	
MALE		WHITE		DEC. 31, 1920		47 YRS		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
MARYLAND			U.S.A.						WASHINGTON Md.		
10. CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
HAGERSTOWN				WASHINGTON CO. HOSPITAL				TRACTOR OPERATOR		CENTRAL CHEMICAL CO.	
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY, TOWNSHIP?		13e STREET AND NUMBER	
MARYLAND				WASHINGTON		BOONSBORO		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		ROUTE # 1	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
First Middle Last				First Middle Last							
CALVIN E. KLINE				ADA LIZER							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS ROUTE # 1					
NO				213-18-9408		MRS. ARBUTUS C. KLINE, BOONSBORO, MARYLAND.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>											Sudden
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) <u>Coronary artery disease</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
				19							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or RFD No. City or Town County State			
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED 5/20/68			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				580 NORTHERN AVE.			
HOWARD N. WEEKS, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) HAGERSTOWN, MARYLAND.			
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
BURIAL				5/21/68		WOLFVILLE CEMETERY		WOLFVILLE, FRED. CO. MD.			
24. FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Charles E. Rogers				HAGERSTOWN, MARYLAND.				DATE MAY 24 1968		Charles Judge	



MEDICAL CERTIFICATION

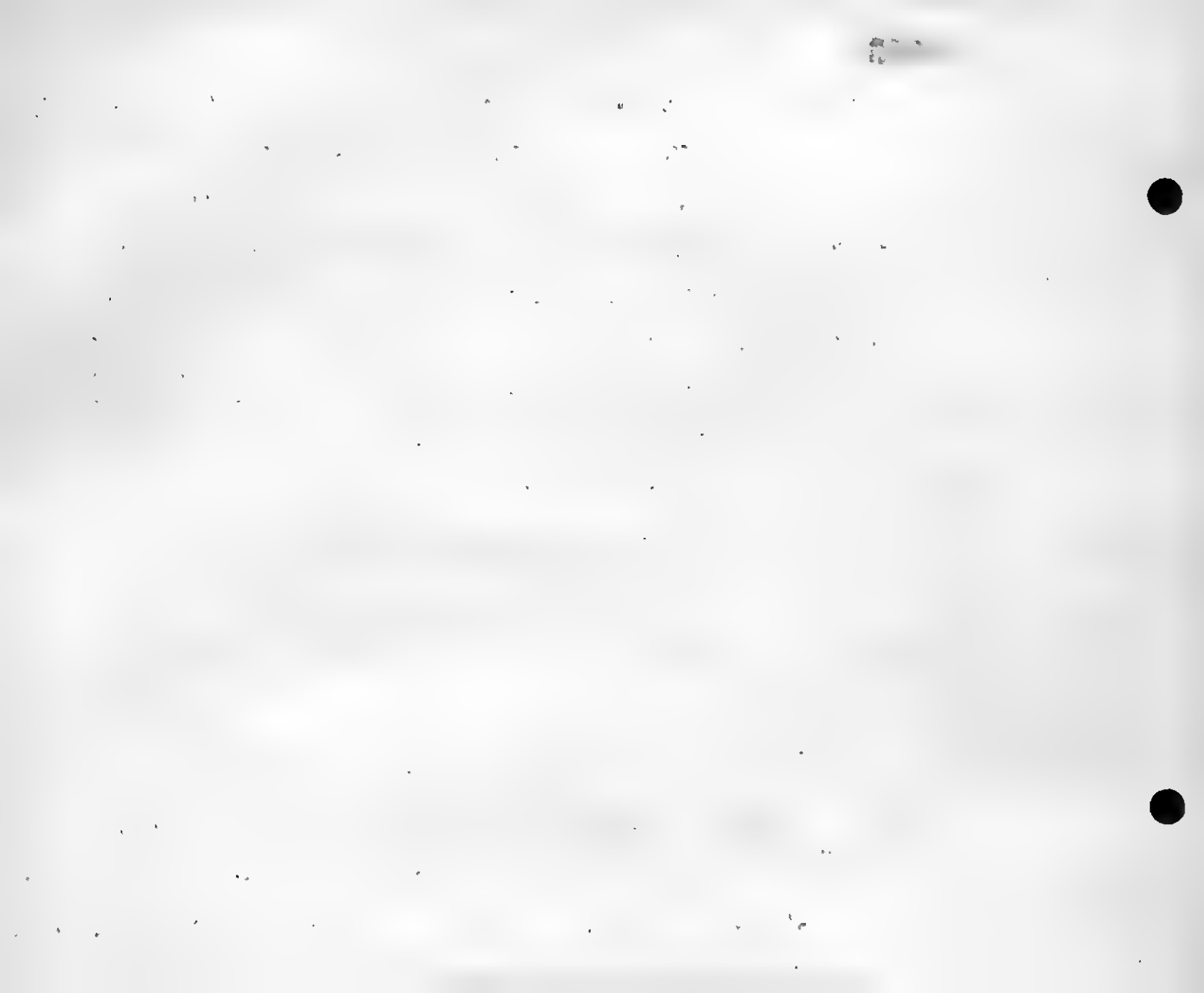
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month / Day / Year			2b. HOUR		
CLARA				EDWINA	LOTZ	5 / 12 / 68			1:25A		
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
FEMALE		WHITE		FEBRUARY 20, 1898		70 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
OHIO		U.S.A.				WASHINGTON Md.					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
HAGERSTOWN		WASHINGTON CO. HOSPITAL				HOMEMAKER		OWN HOME			
13a. USUAL RESIDENCE (Where deceased lived, admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM TST YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
OHIO		MONTGOMERY		KETTERING				4091 OVERLAND TRAIL			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
WILLIAM			J.	GLAZE		CLARA				MACE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT			6 Address			
NO			NOT KNOWN		ROUTSONG FUNERAL HOME, DAYTON 9, OHIO.			OAKWOOD AVENUE,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u>										1 hour	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>Atherosclerotic Heart Disease</u>										6 hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4301 None										Unknown	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (the hospital) attended the deceased from <u>May 11</u> , 19 <u>68</u> , to <u>May 12</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>May 12</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>William T. Layman, M.D.</i>					DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/13/68		
22b. PHYSICIAN'S NAME (Type)					22e. ADDRESS						
WILLIAM T. LAYMAN, M.D.					PROFESSIONAL ARTS BLDG., HAGERSTOWN, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
BURIAL		5/16/68		WOODLAND CEMETERY		DAYTON, MONTGOMERY, OHIO.					
24. FUNERAL DIRECTOR <i>Charles R. Leuger</i>					ADDRESS HAGERSTOWN, MARYLAND.		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
					MAY 15 1968						



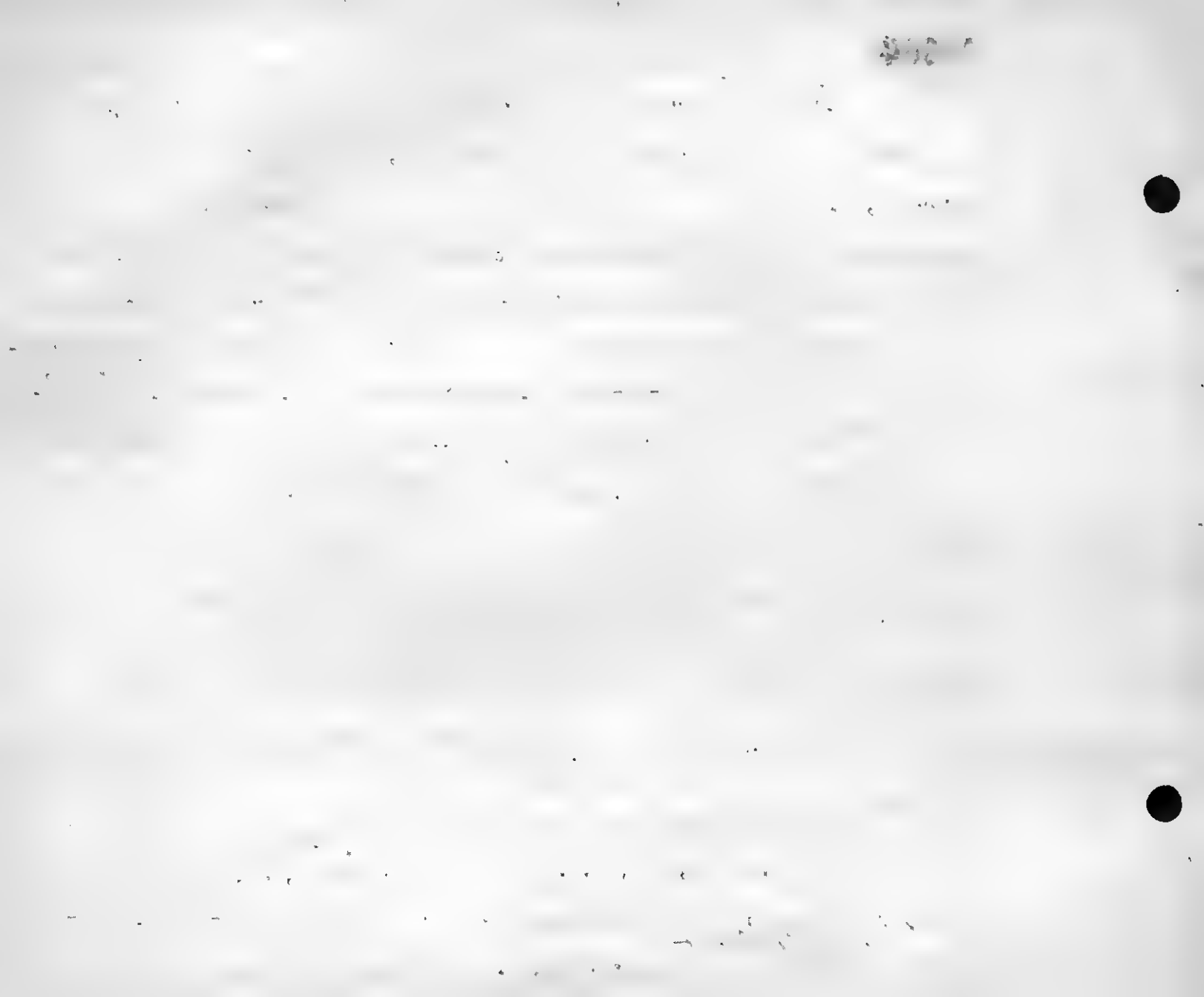
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1

MD. STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

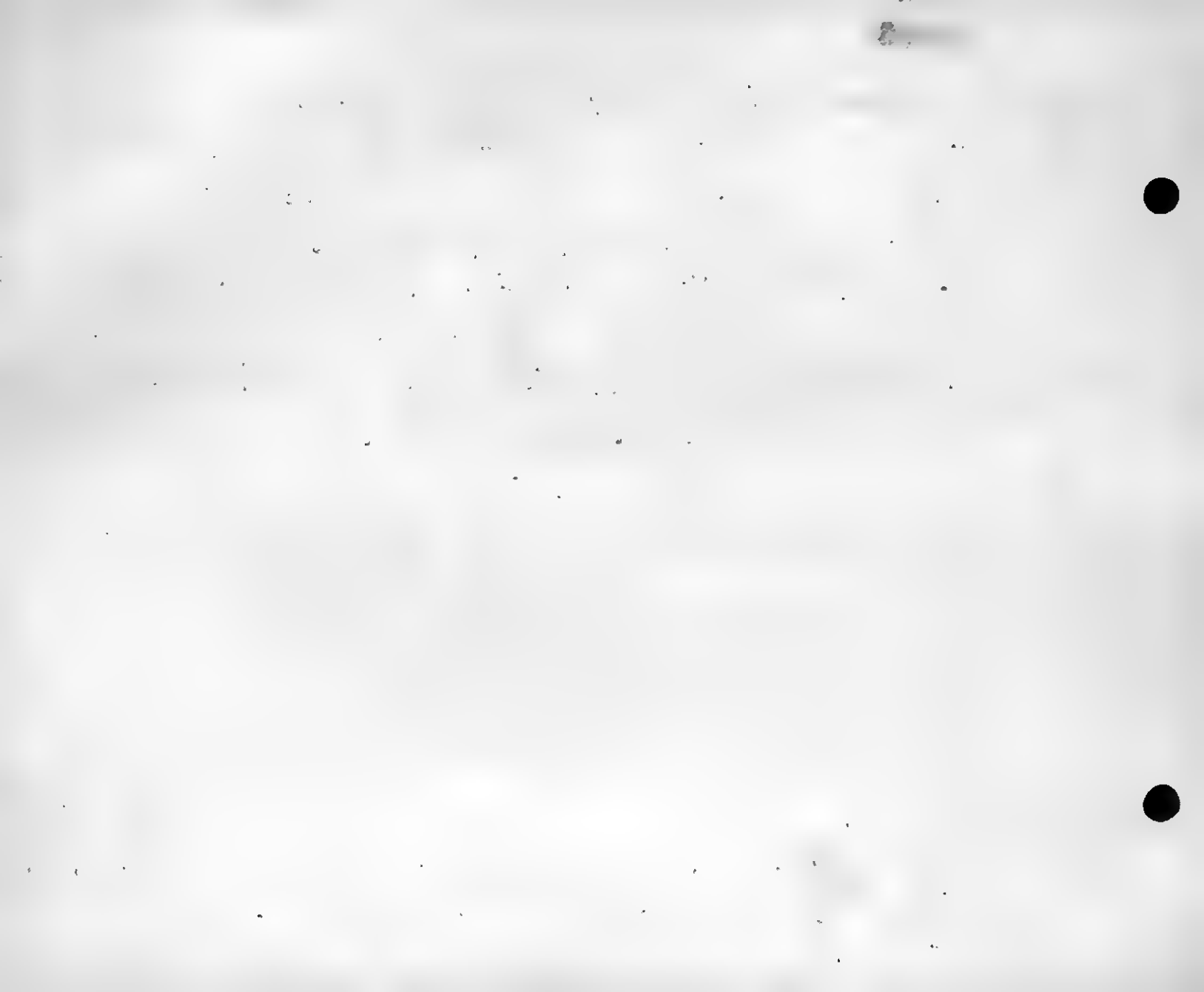
1. DECEASED-NAME (Type or print) First Middle Last <i>Elva Evaline Lynch</i>			2a. DATE OF DEATH Month Day Year <i>May 16 1968</i>			2b. HOUR M <i></i>					
3 SEX <i>Female</i>		4. RACE <i>White</i>		5 DATE OF BIRTH <i>January 10, 1905</i>		6 AGE (In years last birthday) <i>63</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS <i></i>		IF UNDER 24 HRS. HOURS MIN. <i></i>	
7a. BIRTHPLACE (State or foreign country) <i>Hagerstown, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8- MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Washington</i> Md.					
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Washington County Hospital</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>			
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>405 N. Potomac St.</i>			
14 FATHER'S NAME First Middle Last <i>William Blair Werst</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Mary Bertha Hefflefinger</i>								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (or if unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>160-16-6289</i>		17 INFORMANT Address <i>Mr. Richard Werst 243 E. Potomac St. Williamsport, Md.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Mesenteric thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF <i>complication - surgery for</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>5705</i> (b) <i>Acute intestinal obstruction</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>12 days</i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Arteriosclerotic Heart Disease</i>											
19a. DATE OF OPERATION <i>5-5-68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Intestinal obstruction</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>Mar 30, 1968</i> to <i>May 16, 1968</i> , that (I) (we) last saw the deceased alive on <i>May 16, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Edward W. Ditto III</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>5-17-68</i>					
22d. PHYSICIAN'S NAME (Type) <i>Edward W. Ditto, III, M.D.</i>				22e. ADDRESS <i>217 W. Washington Street Hagerstown, Maryland</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>May 19, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Hagerstown - Washington-Md</i>					
24 FUNERAL DIRECTOR <i>Wm. C. Host</i>		ADDRESS <i>Rest Haven Funeral Chapel Hagerstown, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>May 21 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



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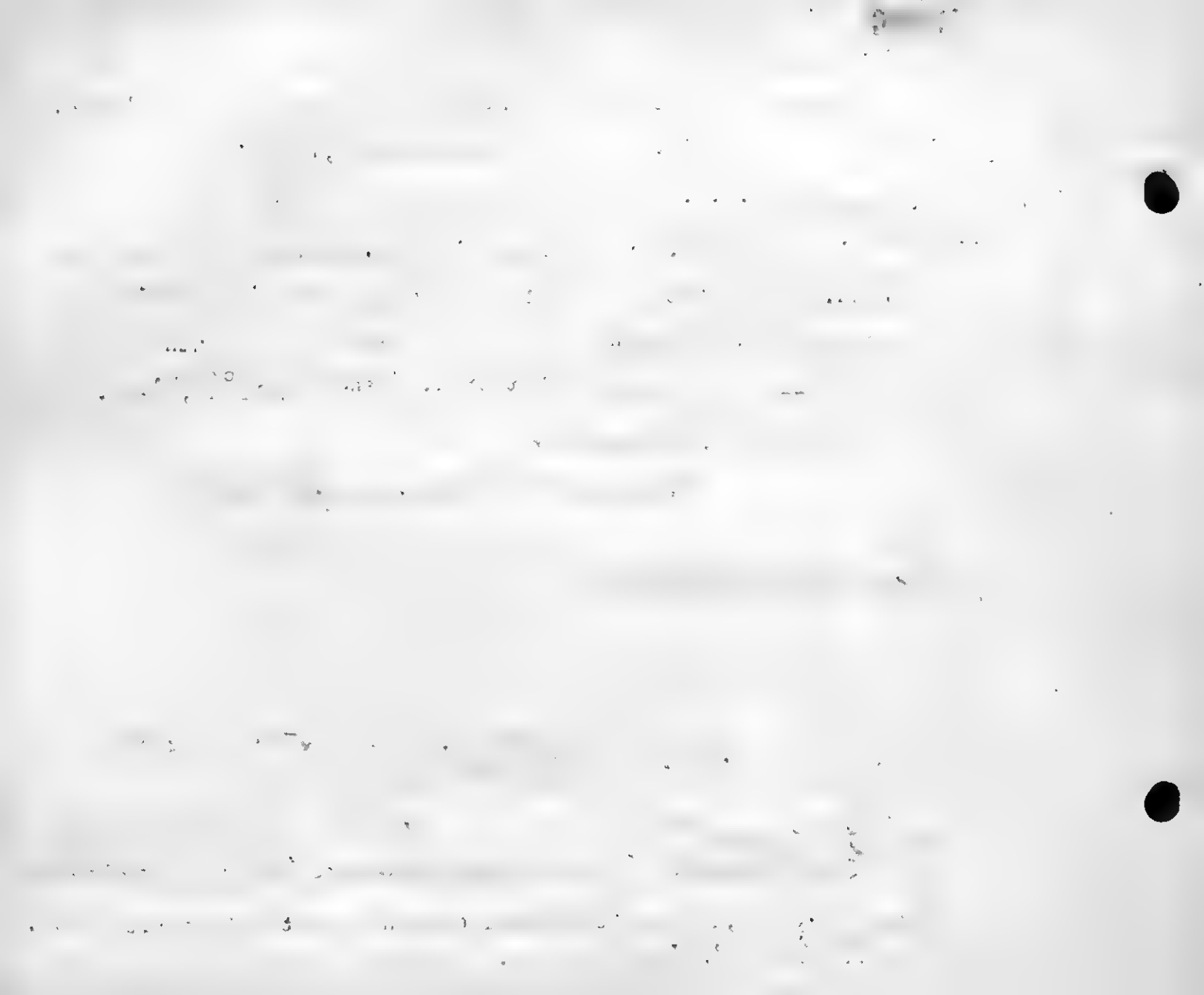
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) BABY GIRL MARTIN			2a. DATE OF DEATH Month 7 Day 16 Year 1968			2b. HOUR 6:10 AM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MAY 6, 1968		6. AGE (in years last birthday) 1 YRS. 1 MONTHS 10 DAYS		7. UNDER 1 YEAR MONTHS 1 DAYS 10	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON			
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASH. Co. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NONE		12b. KIND OF BUSINESS OR INDUSTRY NONE			
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE MARYLAND		13b. COUNTY WASH.		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIM 1ST YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2445 Marsh Pike Hagerstown Wash. Co., Md.	
14. FATHER'S NAME First NELSON Middle H. Last MARTIN			15. MOTHER'S MAIDEN NAME First DOROTHY Middle ARLENE Last (ERY) MARTIN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (or unknown) (If yes, give war or dates of service)			16b. SOCIAL SECURITY NO NONE			17. INFORMANT John H. Martin Address 2445 Marsh Pike Hagerstown Wash. Co., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7761 Immaturity Hyaline membrane disease DUE TO, OR AS A CONSEQUENCE OF (b) Immaturity DUE TO, OR AS A CONSEQUENCE OF (c) Immaturity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7735									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. 19 Month 7 Day 16 Year 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John D. Turco, M. D.				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/17/68			
22d. PHYSICIAN'S NAME (Type) John D. Turco, M. D.				22e. ADDRESS 363 S. Cleveland Avenue Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5/17/68		23c. NAME OF CEMETERY OR CREMATORY Keith Church Cem.		23d. LOCATION (City or Town) (County) (State) near Bearfoss, Md.			
24. FUNERAL DIRECTOR A.E. Mummich - GREENCASTLE, PENNA.				25a. REC'D BY REGISTRAR DATE MAY 9 1968		25b. REGISTRAR'S SIGNATURE John D. Turco			



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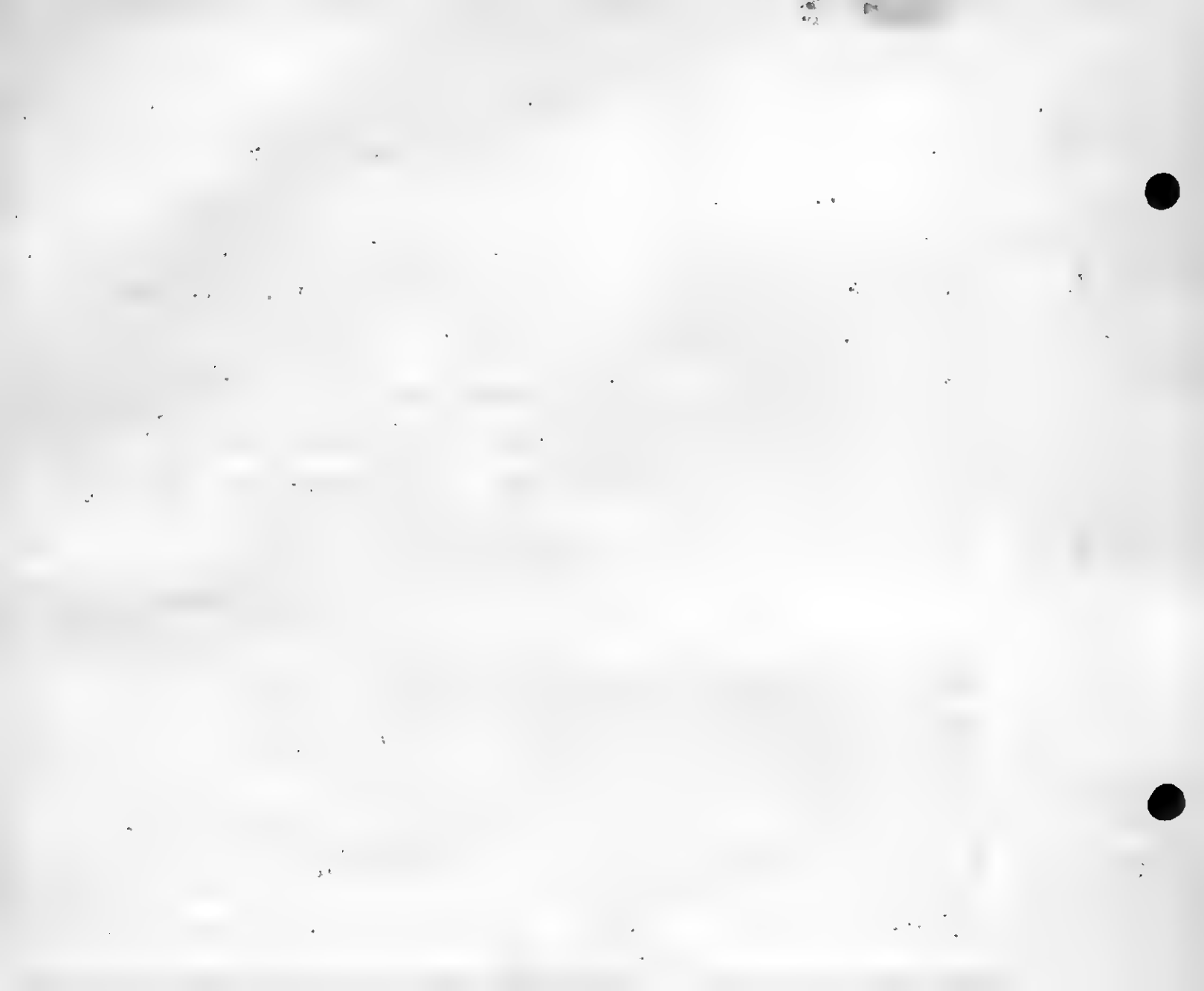
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR A M	
Vella Estelle Mason						May 25, 1968		4:45 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER YEAR MONTHS	
Female		White		September 24, 1908		56 YRS.		7. UNDER YEAR MONTHS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
N. Carolina		U.S.A.				Washington			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown.		Wash. County Hospital		Housewife		Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Penn.		Bucks		Holland				361 Buck Road	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Joseph A Parsons			Dove Kinsey						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		None		Luther L. Mason		361 Buck Rd. Holland, Penn.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Glomerulonephritis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Seafates Mollitus</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>May 15, 1968</u> , to <u>5-25, 1968</u> , that (I) (we) lost saw the deceased alive on <u>5-24, 1968</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		22e. DATE SIGNED			
<u>Francisco E. Rosillo</u>		FRANCISCO E. ROSILLO		580 Northern Ave. Hagerstown		5-25-68			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		May 29, 1968		White Chapel Gardens		Feasterville Buck Penn.			
24. FUNERAL DIRECTOR Hagerstown, Md.				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Andrew K. Coffman Funeral Home Inc.						MAY 28 1968		<u>Charles Judge</u>	



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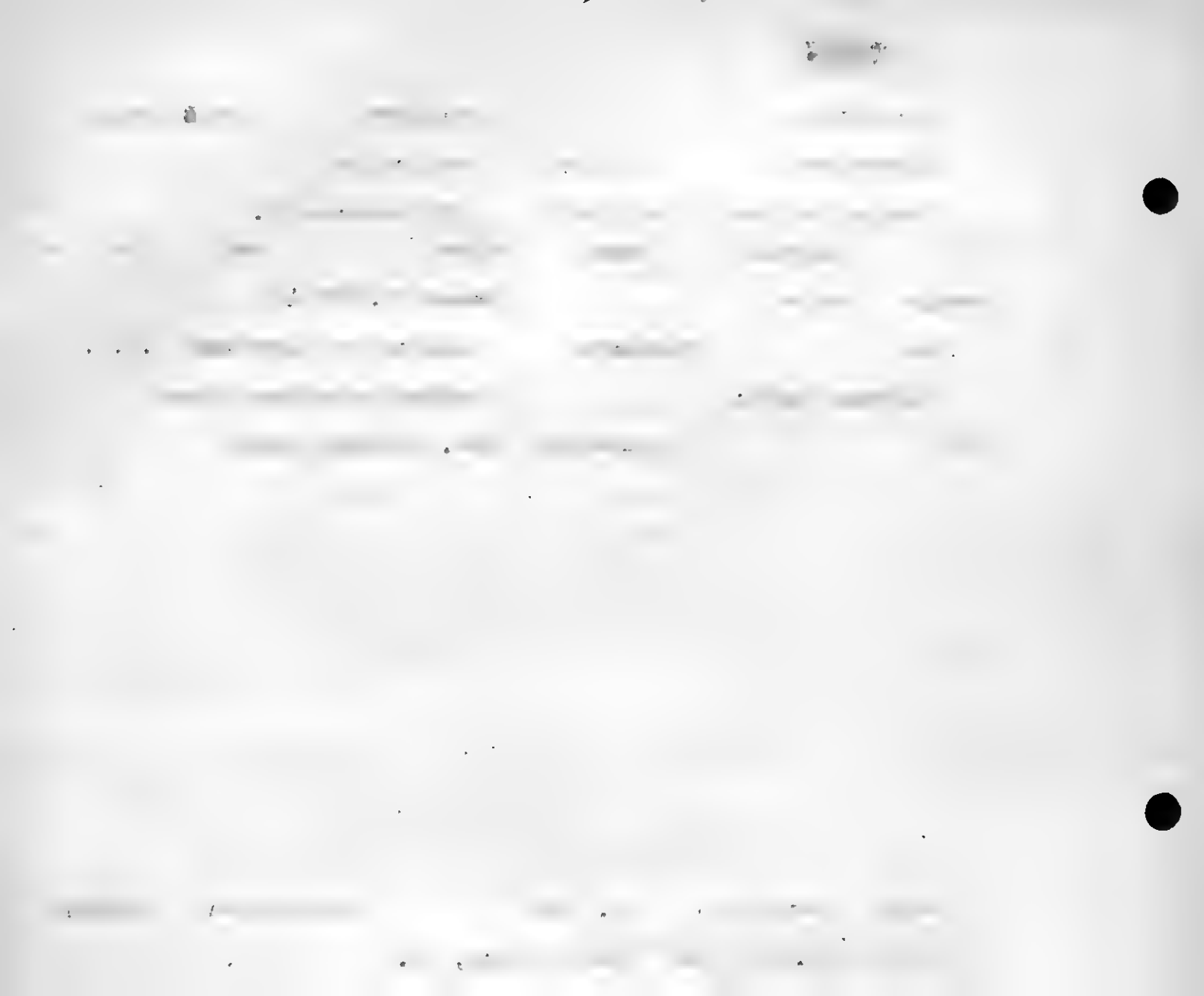
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item #11, Film G401 6/5/68 km									
1. DECEASED NAME					2a. DATE OF DEATH			2b. HOUR	
First Middle Last					Month Day Year			Hour	
JAMES MICHAEL MCGUFFIN, SR.					May 24 68			6:15 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
MALE		WHITE		November 23, 1892		75 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
NORRISTOWN, PA.		U.S.A.				WASHINGTON Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
HAGERSTOWN, MD.		513 W. Franklin St.		RETIRED FOREMAN		HOSTERY MFG.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER			
HAGERSTOWN		WASHINGTON		HAGERSTOWN		513 W. FRANKLIN ST.			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
THOMAS MCGUFFIN			MARY FOLEY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT				
YES			WW I		513 W FRANKLIN ST HAGERSTOWN, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Coronary artery thrombosis</u>								30 min	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute dilatative heart disease</u>								4 years	
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from <u>4/24</u> , 19 <u>63</u> , to <u>5/24</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/10</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				22c. DATE SIGNED					
<u>George Jennings</u> M.D.				5/24/68					
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
GEORGE JENNINGS, M.D.				18 N. POTOMAC ST. HAGERSTOWN, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		5/27/68		ROSE HILL CEM.		HAGERSTOWN WASHINGTON CO., MD.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<u>Charles S. Jennings</u>		HAGERSTOWN, MARYLAND		MAY 31 1968		<u>James Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Delaware b. COUNTY New Castle			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 10 Days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 525 Delaware St.			
3. NAME OF DECEASED (Type or print) Martha Susan Miles				4. DATE OF DEATH May 24 1968			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1920	9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR: Months 4 Days 18 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook			10b. KIND OF BUSINESS OR INDUSTRY Cafeteria		11. BIRTHPLACE (County & State, or foreign country) Washington Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Clarence Martin				14. MOTHER'S MAIDEN NAME Beulah Catherine Grove			
15. WAS DECEASED EVER IN U.S. ARMY OR NAVY? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 214-09-8351		17. INFORMANT Mrs. Woodrow Poole Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dissecting Aneurysm Arch Aorta (b) Periarteritis Nodosa (c) None PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							INTERVAL BETWEEN ONSET AND DEATH 72 hours 18 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 2 1967 to May 24 1968 , that (I) have saw the deceased alive on May 24 1968 , and that death occurred at 10:05 PM from the causes and on the date stated above.							
22a. SIGNATURE <i>Archie Robert Cohen</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 05/26/68	
22c. PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.				22d. ADDRESS Clear Spring, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 27, 68		23c. NAME OF CEMETERY OR CREMATORY St. Paul		23d. LOCATION (City, town or county) (State) Washington Maryland	
24. FUNERAL DIRECTOR <i>Donald E. Thompson</i>				25a. REC'D BY REGISTRAR MAY 31 1968		25b. REGISTRAR'S SIGNATURE <i>John L. Judge</i>	

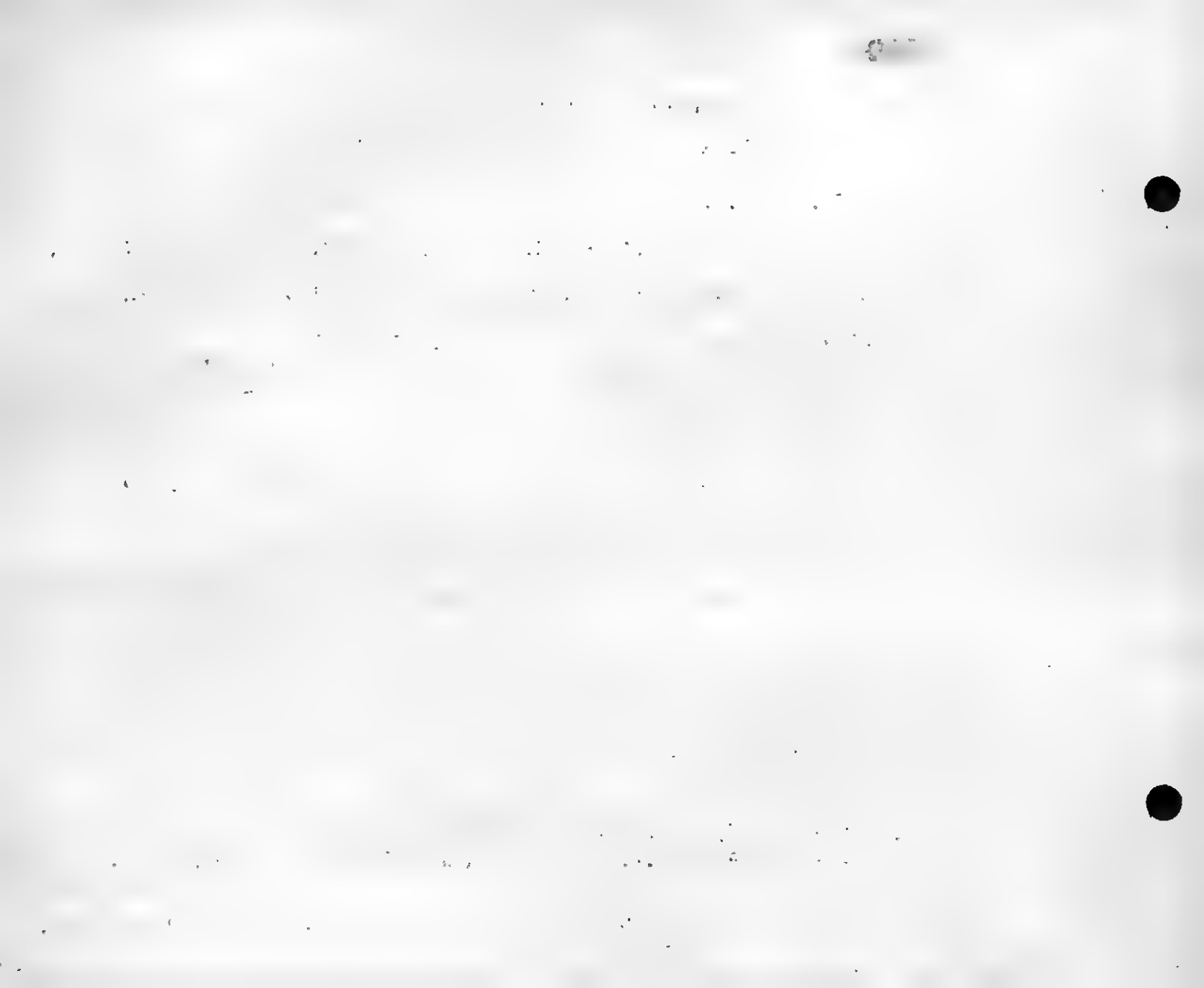
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARTLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
FRED BENFRED MILLER						May 23 68			8:15a M
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 24 HRS.	
MALE		WHITE		OCT. 15, 1889		78 YRS.		MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
BLOSERVILLE, PA.		U.S.A.				WASHINGTON Md.			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
HALFWAY, MD.			2104 EVERGREEN DR.			TRUSS MFG.			TRUSS MFG.
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d INSIDE CITY LIM TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
MD.			WASHINGTON		HALFWAY			2104 E. EVERGREEN DR.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			
WILLIAM H. MILLER						MENTIE CHARLTON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes (no or unknown))			16b SOCIAL SECURITY NO.		17 INFORMANT				
NO			217-10-2623		MRS ALICE H. MILLER 2104 EVERGREEN DR. HALFWAY, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>4104</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 yr.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>4201</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the physician) attended the deceased from <u>Feb. 1961</u> to <u>May 23, 1968</u> , that (I) (we) saw the deceased alive on <u>May 23, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Lloyd A. Hoffman</u>					DEGREE	ATTENDING PHYS.	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <u>5/24/68</u>
22d. PHYSICIAN'S NAME (Type) LLOYD A. HOFFMAN, M.D.					22e. ADDRESS 214 N POTOMAC ST. HAGERSTOWN, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		5/27/68		REST HAVEN CEM.		HAGERSTOWN, WASHINGTON, C. MD.			
24. FUNERAL DIRECTOR <u>Charles S. Miller</u>		ADDRESS HAGERSTOWN, MARYLAND		25a. REC'D BY REGISTRAR DATE MAY 31 1968		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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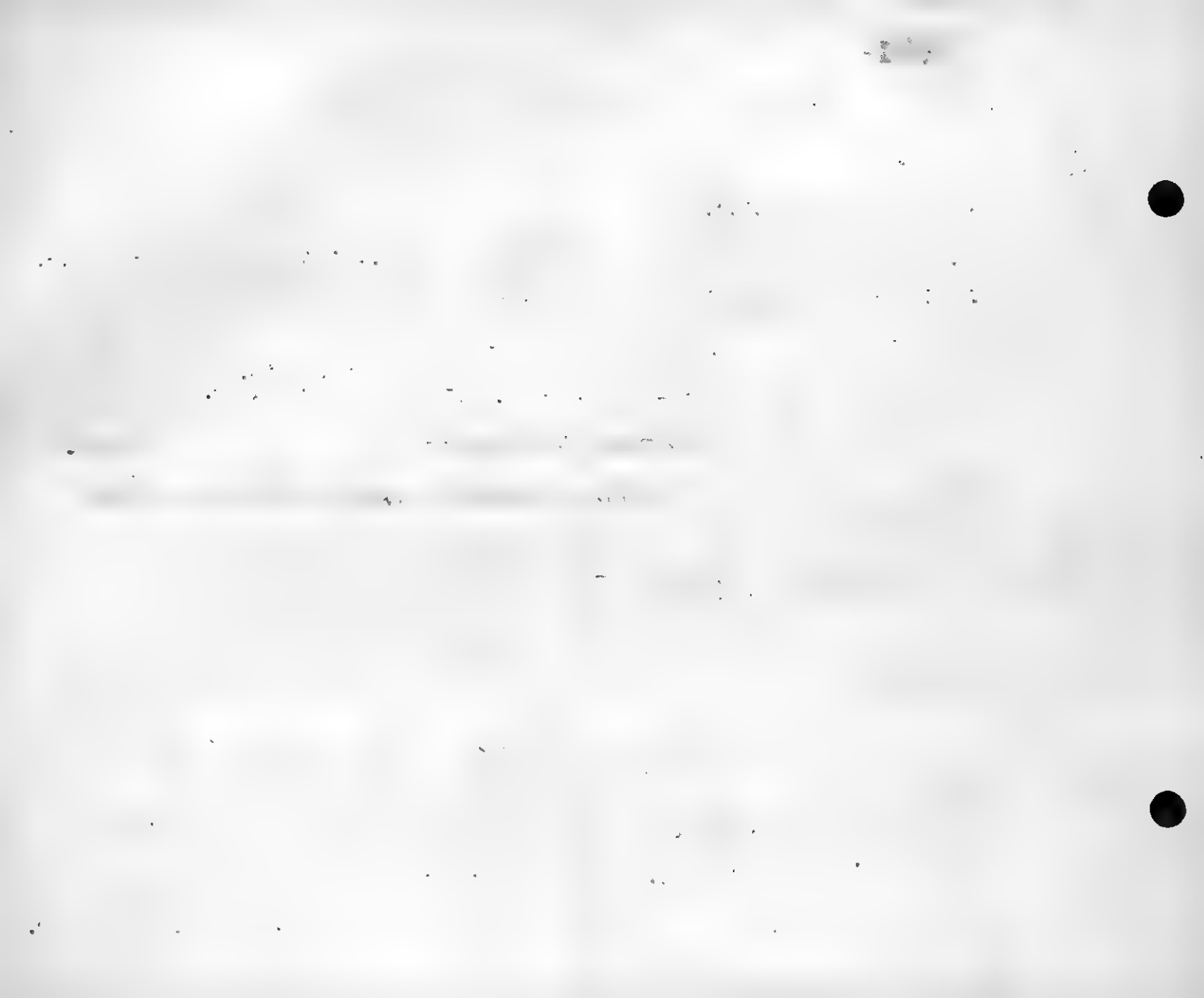
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Daniel Willard Moats					2a. DATE OF DEATH 5 Month 18 Day 68 Year			2b. HOUR 10:15 PM	
3 SEX male		4. RACE white		5. DATE OF BIRTH July 19, 1909		6 AGE (In years lost birthday) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. Co. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) office supervisor		12b. KIND OF BUSINESS OR INDUSTRY insurance			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Wash.		13c. CITY OR TOWN Boonsboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rd. # 1	
14. FATHER'S NAME First Leslie J. Middle Moats				15. MOTHER'S MAIDEN NAME First Mary Ellen Middle Lambert Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 214-09-8436		17. INFORMANT Address Ethel Moats Boonsboro Rd1 Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Edema of heart - lung, getting worse DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerosis of heart DUE TO, OR AS A CONSEQUENCE OF (c) 4 x 100 mm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION 5-21-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1-20-68 , 19 68 , to 5-18 , 19 68 , that (I) (we) last saw the deceased alive on 5-18 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. L. J. Moats		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. DATE-SIGNED 5-18-68									
22d. PHYSICIAN'S NAME (Type) Dr. L. J. Moats		22e. ADDRESS 500 W. Preston St. Baltimore, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 5-21-68		23c. NAME OF CEMETERY OR CREMATORY Manor Church Cemetery		23d. LOCATION (City or Town) (County) (State) Tilghmanton Md.			
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.				25a. REC'D BY REGISTRAR DATE MAY 24 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) CHARLES		First	Middle	Last	2a DATE OF DEATH May Month 24 Day 68 Year		2b HOUR 5:50 AM	
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH FEB. 7, 1906		6. AGE (in years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS
7a BIRTHPLACE (State or foreign country) BARMEN, GERMANY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Md.		
10 CITY OR TOWN OF DEATH HAGERSTOWN		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 13. COUNTY WASHINGTON		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MGR., FACTORY		12b. KIND OF BUSINESS OR INDUSTRY RIBBON MFG.		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) - STATE HAGERSTOWN		13b. CITY OR TOWN HAGERSTOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 331 Key Avenue		
14. FATHER'S NAME KARL		First	Middle	Last	15. MOTHER'S MAIDEN NAME ELVIRA		First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		(If yes give war or dates of service)		16b SOCIAL SECURITY NO 151-05-7042		17 INFORMANT MARIA MUELLER		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease stating the underlying cause last. 42-1 (c) 3 yrs.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Isotonic status								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (the hospital) attended the deceased from May 22, 1968 to May 24, 1968 , that (I) (we) last saw the deceased alive on May 24, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Adrian Novenstein		DEGREE MD.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/25/68		
22d. PHYSICIAN'S NAME (Type) ADRIAN NOVENSTEIN, M.D.		22e. ADDRESS FUNKSTOWN, MD.						
23a. BURIAL, CREMATION, RENAISSANCE (Specify)		23b. DATE 5/27/68		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASHINGTON CO., MD.		
24. FUNERAL DIRECTOR Charles M. Rager		ADDRESS HAGERSTOWN, MARYLAND		25a. REC'D BY REGISTRAR MAY 31 1968		25b. REGISTRAR'S SIGNATURE James Judge		

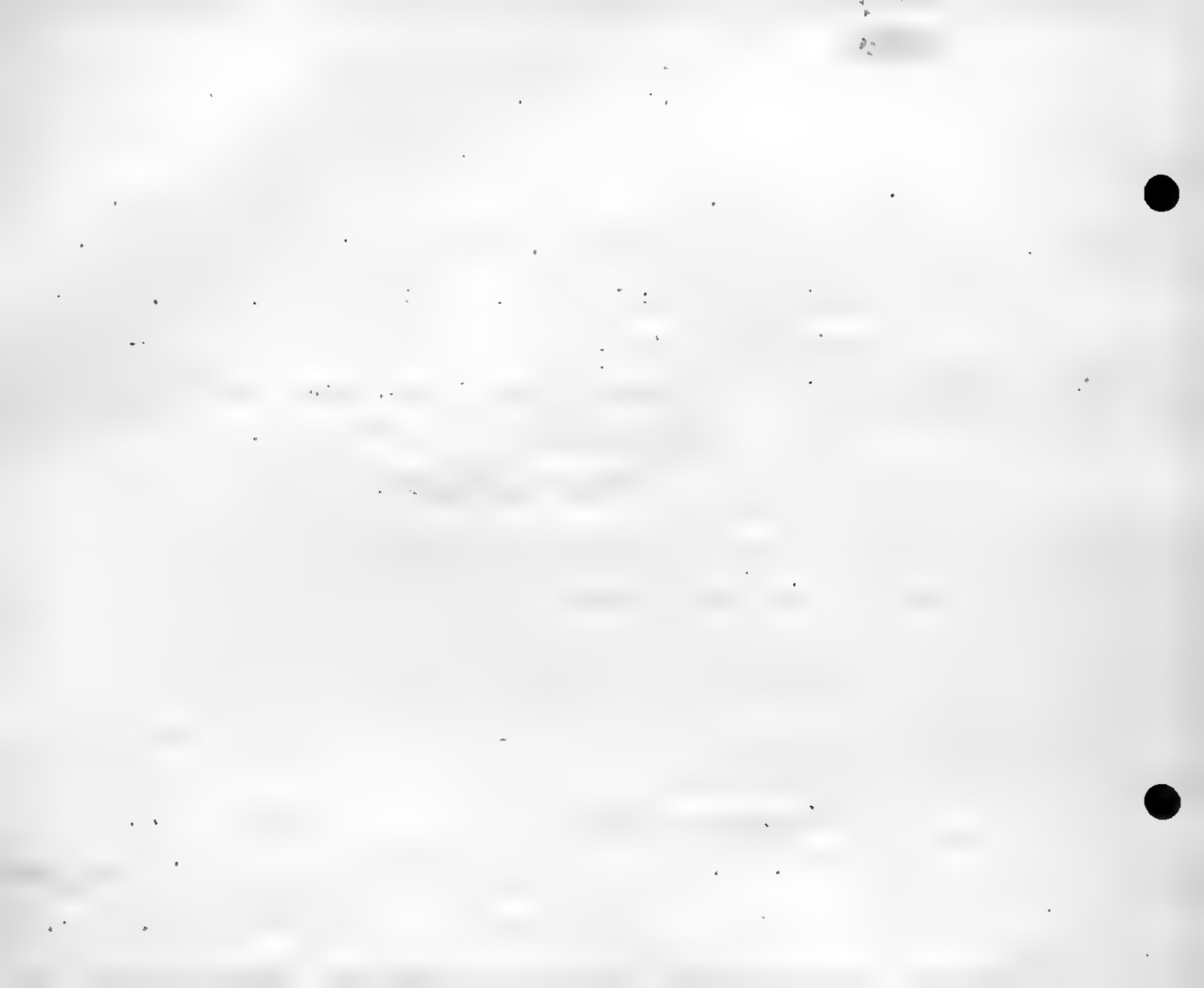


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) JILL ELISE MUMMA			2a DATE OF DEATH Month 5 / Day 14 / Year 68		2b HOUR 7:30PM
3 SEX FEMALE	4 RACE WHITE	5 DATE OF BIRTH MAY 3, 1968		6 AGE (In years last birthday) YRS 1	IF UNDER 1 YEAR MONTHS 1 DAYS 1
7a BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 COUNTY OF DEATH WASHINGTON Md.		10 CITY OR TOWN OF DEATH HAGERSTOWN			
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON CO. HOSPITAL		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) ****		12b KIND OF BUSINESS OR INDUSTRY ****	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13b COUNTY WASHINGTON		13c CITY OR TOWN HAGERSTOWN	
13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER WASHINGTON CO. HOSPITAL			
14 FATHER'S NAME First EDWARD Middle ALLEN Last MUMMA		15 MOTHER'S MAIDEN NAME First GLENDIA Middle WHITLAK Last WHITLAK			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service) *****		16b SOCIAL SECURITY NO NONE		17. INFORMANT MR. EDWARD A. MUMMA, HAGERSTOWN, MARYLAND.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ateletary of lungs. DUE TO, OR AS A CONSEQUENCE OF Pneumonia. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 16 x 2					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year 19 P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____	
22a. I certify that (I) (did not) attended the deceased from 5-3-68 , 19 68 , to 5-4- , 19 68 , that (I) (was) saw the deceased alive on 5-4-68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b SIGNATURE <i>Francisco E. Rosillo</i>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 5/6/68	
22d PHYSICIAN'S NAME (Type) FRANCISCO E. ROSILLO, M.D.		22e ADDRESS 580 NORTHERN AVE. HAGERSTOWN, MARYLAND.			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5/6/68		23c NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	
23d LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD.		24 FUNERAL DIRECTOR <i>Upton L. Eichelberger</i> ROUZER FUNERAL HOME HAGERSTOWN, MARYLAND.			
25a REC'D BY REGISTRAR DATE MAY 8, 1968		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



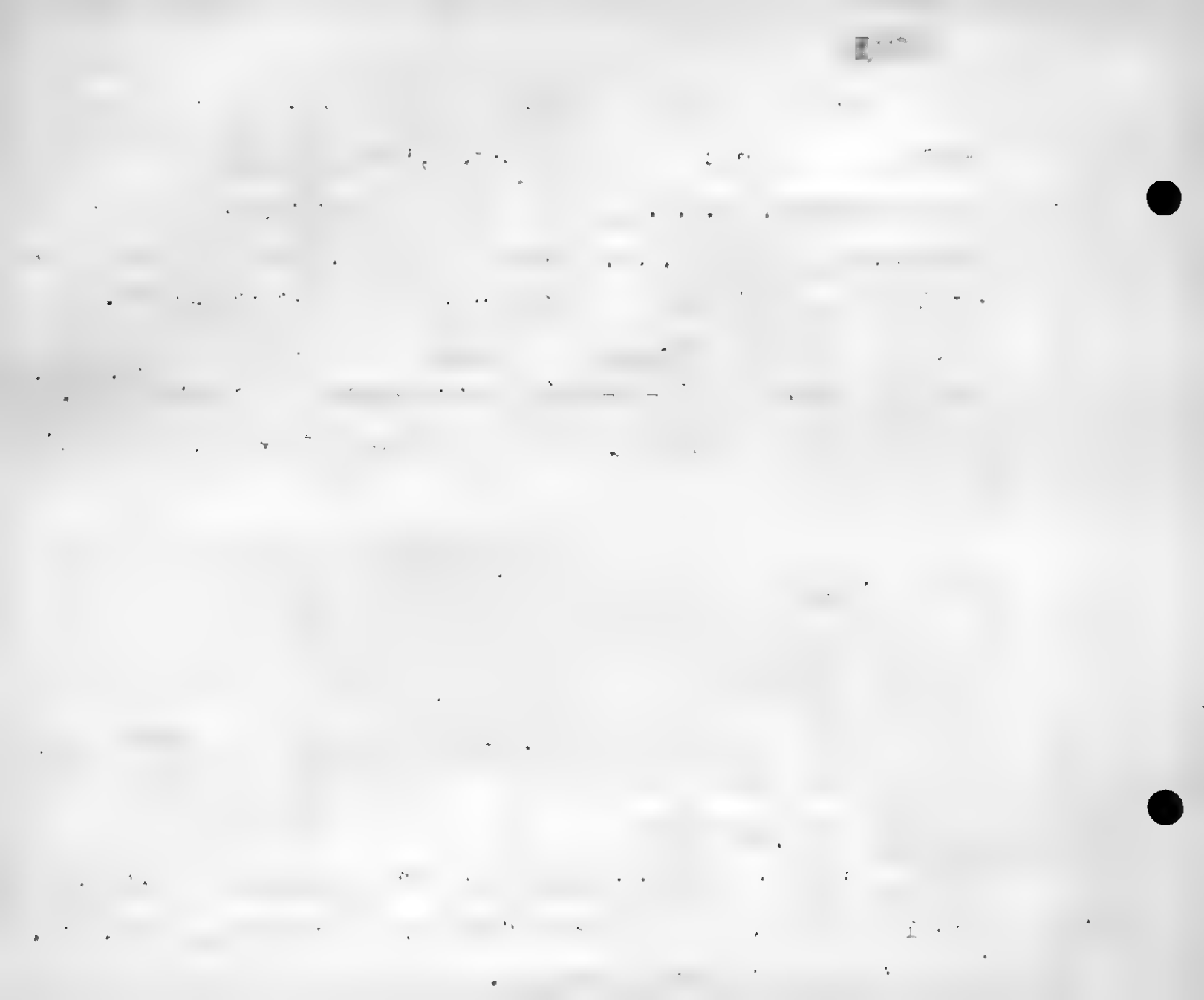
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Edith Mae Mummert			2a. DATE OF DEATH Month May Day 13 Year 1968		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH Nov. 26, 1893		6. AGE (In years last birthday) 74 YRS	
7a. BIRTHPLACE (State or foreign country) Indian Springs, U.S.A.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Washington			10. CITY OR TOWN OF DEATH Hagerstown		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. Co. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Home duties		12b. KIND OF BUSINESS OR INDUSTRY House work	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland COUNTY Washington		13b. CITY OR TOWN Hagerstown	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET AND NUMBER 1725 Wabash Ave.	
14. FATHER'S NAME First Peter Middle # Last Forsythe		15. MOTHER'S MAIDEN NAME First Mary Middle # Last Snyder		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) None	
16b. SOCIAL SECURITY NO. 217-32-5628B		17. INFORMANT Ervin Mummert		Address Hagerstown, Md. 1725 Wabash Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Adenocarcinoma of Stomach with Metastases DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1519 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) P.O. Adenocarcinoma of Recto-Sigmoid 10-25-66					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1-13- , 19 58 , to 5-13 , 19 68 , that (I) (we) last saw the deceased alive on 5-13 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dalton M. Welty		DEGREE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/14/68	
22d. PHYSICIAN'S NAME (Type) Dalton M. Welty, M.D.		22e. ADDRESS 998 Potomac Avenue, Hagerstown, Md. 21740			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 5/16/68		23c. NAME OF CEMETERY OR CREMATORY Shanktown Cemetery	
23d. LOCATION (City or Town) Shanktown		23e. (County) Wash.		23f. (State) Md.	
24. FUNERAL DIRECTOR Margaret Rowland		CLEAR ADDRESS Clear Spring, Md.		25a. RECD BY REGISTRAR MAY 17 1968	
25b. REGISTRAR'S SIGNATURE [Signature]		25c. JUDGE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 11-14
30M REV 1-68



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last Nellie Weagley Newcomer			2a. DATE OF DEATH Month Day Year May 3, 1968		2b. HOUR 10:00PM
3 SEX Female	4. RACE White	5. DATE OF BIRTH June 29, 1876		6. AGE (In years last birthday) 91 YRS.	IF UNDER 1 YEAR MONTHS DAYS 10 4
7a. BIRTHPLACE (State or foreign country) Cavetown, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Washington		Md.			
10. CITY OR TOWN OF DEATH Hagerstown, Md		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Avalon Manor Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY Own Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland		13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 715 Oak Hill Ave.
14. FATHER'S NAME First Middle Last John Weagley		15. MOTHER'S MAIDEN NAME First Middle Last Malenda Necker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No.		16b. SOCIAL SECURITY NO 214-54-0598		17. INFORMANT Hagerstown, Md. Mrs. Dorothy N. Pullman, 715 Oak Hill Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH CAUSED BY: IMMEDIATE CAUSE (a) Malignancy - Peritoneal cavity - t/r? DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic Heart Disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from May 4, 1965 to May 3, 1968 , that (I) (we) last saw the deceased alive on May 1, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE Lloyd A. Hoffmann		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) Lloyd A. Hoffmann		22e. ADDRESS 214 N. Potomac St Hagerstown			
22c. DATE SIGNED 5/4/68					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-6-68		23c. NAME OF CEMETERY OR CREMATORY Beaver Creek Cemetery	
23d. LOCATION (City or Town) (County) (State) Beaver Creek, Wash. Co., Md.					
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		ADDRESS		25a. REC'D BY REGISTRAR MAY 6 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

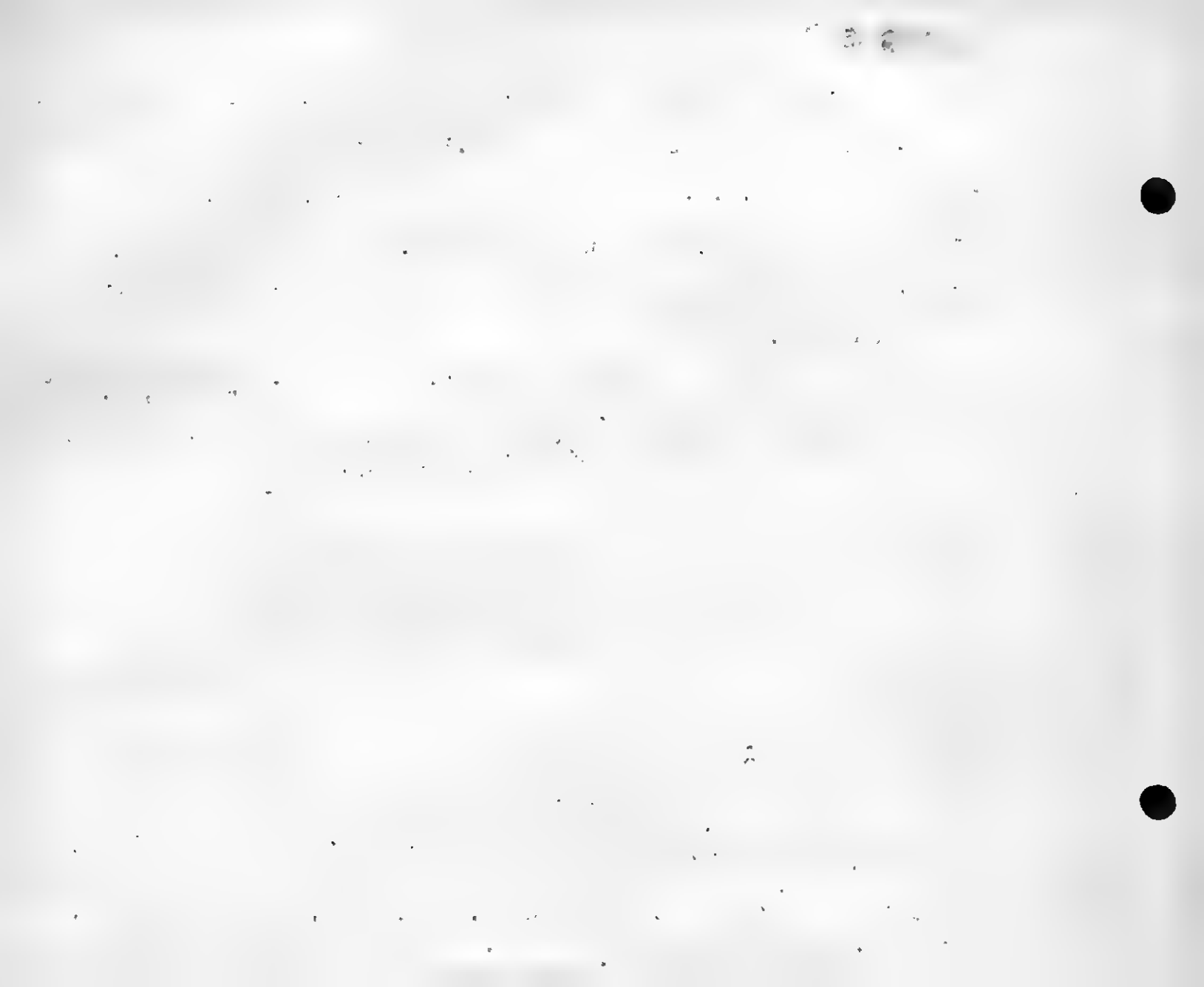
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2) and return them to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115-1
30M REV 7/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21207
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Tina Marie Poole			2a DATE OF DEATH May Month 18 , Day 1968		2b HOUR 1250 P. M.
3 SEX Female	4. RACE White	5. DATE OF BIRTH Nov. 18, 1968		6. AGE (in years last birthday) 1 YRS. 8 MONTHS 6 DAYS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Washington Md.		
10 CITY OR TOWN OF DEATH Hagerstown	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hosp.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None		12b KIND OF BUSINESS OR INDUSTRY None	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. CITY OR TOWN Washington	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d STREET AND NUMBER 46 Alexander Street		
14. FATHER'S NAME First Middle Last James M. Poole		15. MOTHER'S MAIDEN NAME First Middle Last Teresa Ruck			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No (unknown) (If yes give war and date of discharge)		16b SOCIAL SECURITY NO None		17 INFORMANT James M. Poole Address 40 N. Mulberry Street Hagerstown, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Fulminating Meningococcemia DUE TO, OR AS A CONSEQUENCE OF (Waterhouse-Friderichsen Syndrome) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 hrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:(a)					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes.					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or RFD No City or Town County State	
22a I certify that (I) (this hospital) attended the deceased from 5/18/68 , 19____, to 5/18 , 19 68 , that (I) (we) last saw the deceased alive on 5/18/68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE George Jennings		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 5/20/68	
22d. PHYSICIAN'S NAME (Type) George Jennings		22e ADDRESS 318 N. Potomac St. Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL Burial	23b DATE May 20/68	23c NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Garden		23d LOCATION (City or Town) (County) (State) Hagerstown Maryland.	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc.		ADDRESS Hagerstown, Maryland.		25a. REC'D BY REGISTRAR MAY 22 1968	
		25b. REGISTRAR'S SIGNATURE John J. Judge			

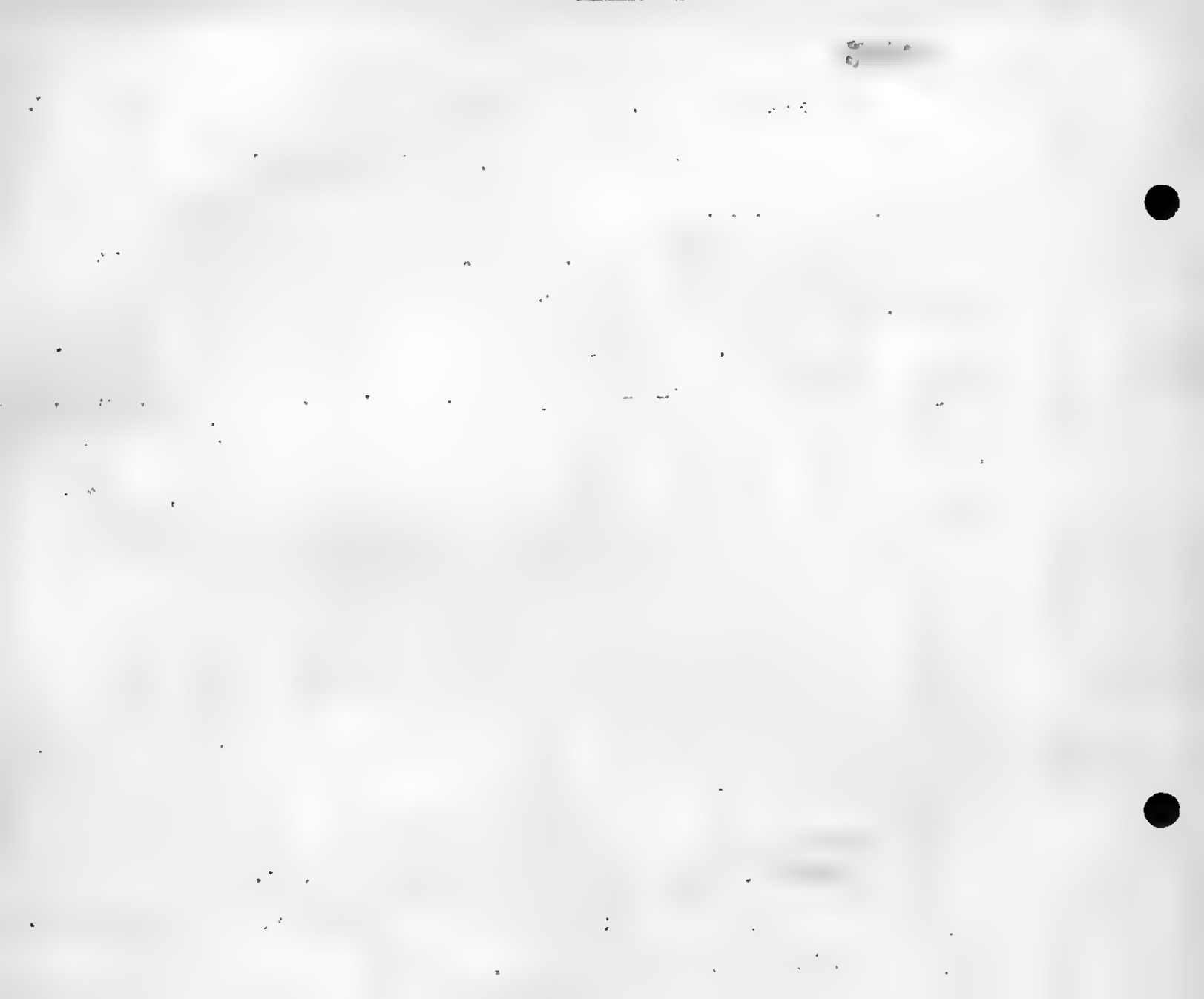


51
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR				
Joseph		H.		Pryor	May 4 1968		2 P. M.				
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Male		White		Aug. 21, 1888		79 YRS.					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Lantz Md.		U.S.A.				Washington Md.					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
Hagerstown		Washington Co., Hospital		Crane Operator		Landis Tool Co.					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER			
Md.		Washington		Highfield		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 18			
14 FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
John		W.		Pryor	Amanda				Brown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b SOCIAL SECURITY NO		17. INFORMANT Address					
No				173-03-0537A		Mrs. Margaret A. Pryor, Highfield Md.					
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Benign prostatic hypertrophy</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>2 yrs.</u> <u>10 yrs.</u>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>2-1, 1958</u> , to <u>5-4, 1968</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>5-4, 1968</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.											
22b. SIGNATURE <u>Charles F. Hess</u> M.D. DEGREE						ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>5-5-68</u>			
22d. PHYSICIAN'S NAME (Type) <u>Charles F. Hess</u>						22e. ADDRESS <u>Smithsburg, Md.</u>					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		5/7/68		Bethel		Lantz #1 Frederick Md.					
24. FUNERAL DIRECTOR <u>Walter Z. Grove</u> Waynesboro Pa.						25a. REC'D BY REGISTRAR DATE <u>MAY 8 1968</u>		25. REGISTRAR'S SIGNATURE <u>James Judge</u>			

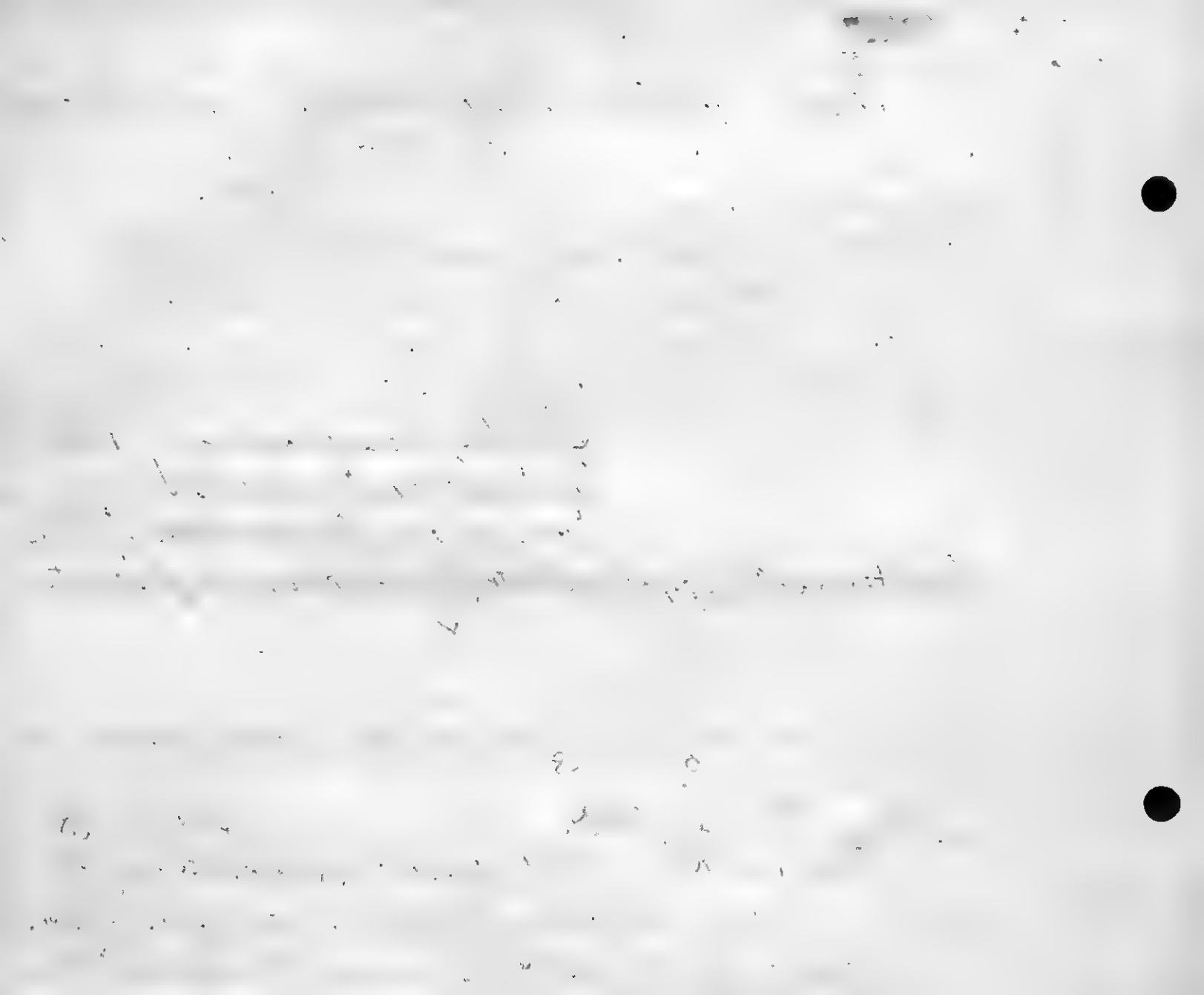


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15 (4)
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item #5, film G401 6/10/68 en CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last Oscar LeVan Raup Jr May						2a. DATE OF DEATH Month Day Year 30 1968			2b. HOUR 7:50 AM		
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH JUNE 8, 1883		6 AGE (In years 1-yr. birthday) 85 75 YRS.		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON					
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY PITNEY BOWERS					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE HAGERSTOWN WASHINGTON		13b. CITY OR TOWN HAGERSTOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 24 CLINTON AVE.					
14. FATHER'S NAME First Middle Last WILLIAM L. RAUP				15. MOTHER'S MAIDEN NAME First Middle Last MARY ELIZABETH CG CRAIG							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO. 170-01-3061		17. INFORMANT MARY LOUISE RAUP HAGERSTOWN, MARYLAND							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular accident CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST: 331x DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus, pyelonephritis, hydronephrosis, hydronephrosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk 5 mon several years	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 2-6 , 19 68 , to 5-29 , 19 68 , that (I) (we) last saw the deceased alive on 5-30 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Edwin G. Riley M.D.				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 5-30-68					
22d. PHYSICIAN'S NAME (Type) Edwin G. Riley M.D.				22e. ADDRESS 1560 Penna, Hagerstown, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6/1/68		23c. NAME OF CEMETERY OR CREMATORY JEFFERSON MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) PLEASANT HILLS, ALLEGHENY, PA.					
24. FUNERAL DIRECTOR Charles W. Koenig				ADDRESS HAGERSTOWN, MARYLAND		25a. REC'D BY REGISTRAR JUN 3 1968		25b. REGISTRAR'S SIGNATURE Charles J. J...			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Wilbur Stroh Remsberg			2a DATE OF DEATH Month May Day 21 Year 1968			2b HOUR 6.15 M				
3 SEX Male		4 RACE White		5 DATE OF BIRTH Feb 28 1898		6 AGE (In years last birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md				
10. CITY OR TOWN OF DEATH Hagerstown		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1208 H amilton Blvd		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Draftsman		12b KIND OF BUSINESS OR INDUSTRY Designer				
13a USUAL RESIDENCE (Where deceased lived, if institut an: Residence before admission) STATE Maryland		13b COUNTY Washington		13c CITY OR TOWN Hagerstown		13d INS. OR CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1208 Hamilton Blvd		
14. FATHER'S NAME First Middle Last Rev Dr. Wilson L. Remsberg			15 MOTHER'S MAIDEN NAME First Middle Last Katie Stroh							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. ---		17. INFORMANT Mrs Jessie B. Remsberg		Address Hagerstown Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4100 DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE-ARTERIOSCLEROTIC C-V DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) --- Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES Yes.				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 18 Dec , 1964, to 21 May , 1968, that (I) (we) last saw the deceased alive on 16 April , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE W.N. FENDER M.D. DEGREE				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 21 May 1968				
22d. PHYSICIAN'S NAME (Type) W.N. FENDER				22e. ADDRESS 218 N. Potomac St., Hagerstown, Md.						
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/24/68		23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		23d. LOCATION (City or Town) (County) (State) Funkstown Wash Co Md.				
24. FUNERAL DIRECTOR Andrew K. Coffman				Funeral Home Inc		25a. REC'D BY REGISTRAR MAY 23 1968			25b. REGISTRAR'S SIGNATURE	

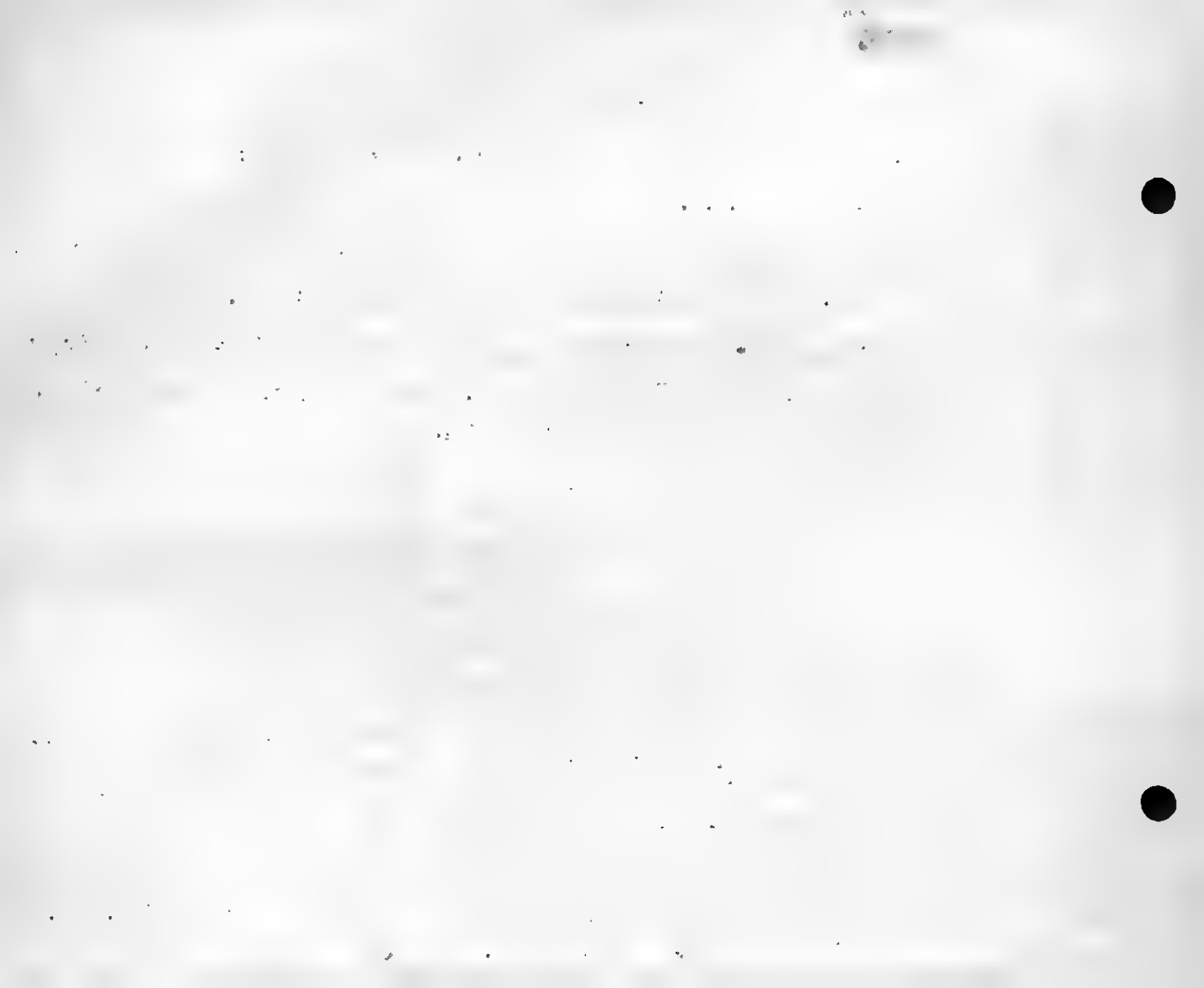
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Robert Thomas Reynolds			2a. DATE OF DEATH Month May Day 3 Year 1968			2b. HOUR			
3. SEX Male		4. RACE White		5. DATE OF BIRTH Nov. 28 1912		6. AGE (In years last birthday) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS M.N.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.			
10. CITY OR TOWN OF DEATH Smithsburg		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rural # 2		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) teacher		12b. KIND OF BUSINESS OR INDUSTRY Public Scho			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before adm ssion) STATE Md.		13b. COUNTY Washington		13c. CITY OR TOWN Smithsburg		13d. INSIDE CITY LIM TS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rural # 2	
14. FATHER'S NAME First Middle Last Allen E Reynolds			15. MOTHER'S MAIDEN NAME First Middle Last Anna Grace Stockslager						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give year or dates of service) No		16b. SOCIAL SECURITY NO. 219-36-3678		17. INFORMANT Address Mrs. Francis L. Reynolds Smithsburg #2 Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral embolism 1919 DUE TO, OR AS A CONSEQUENCE OF (b) Cancer Stomach Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 1 yr.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mos.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Nov 67 , to 3 May 1968 , that (I) (we) last saw the deceased alive on 2 May 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE J. L. Wilson		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/3/68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 5 1968		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		23d. LOCATION (City or Town) (County) (State) Smithsburg Wsh. Md.			
24. FUNERAL DIRECTOR Minnich Funeral Home				ADDRESS Smithsburg Md.		25a. REC'D BY REGISTRAR DATE MAY 7 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

MEDICAL CERTIFICATION

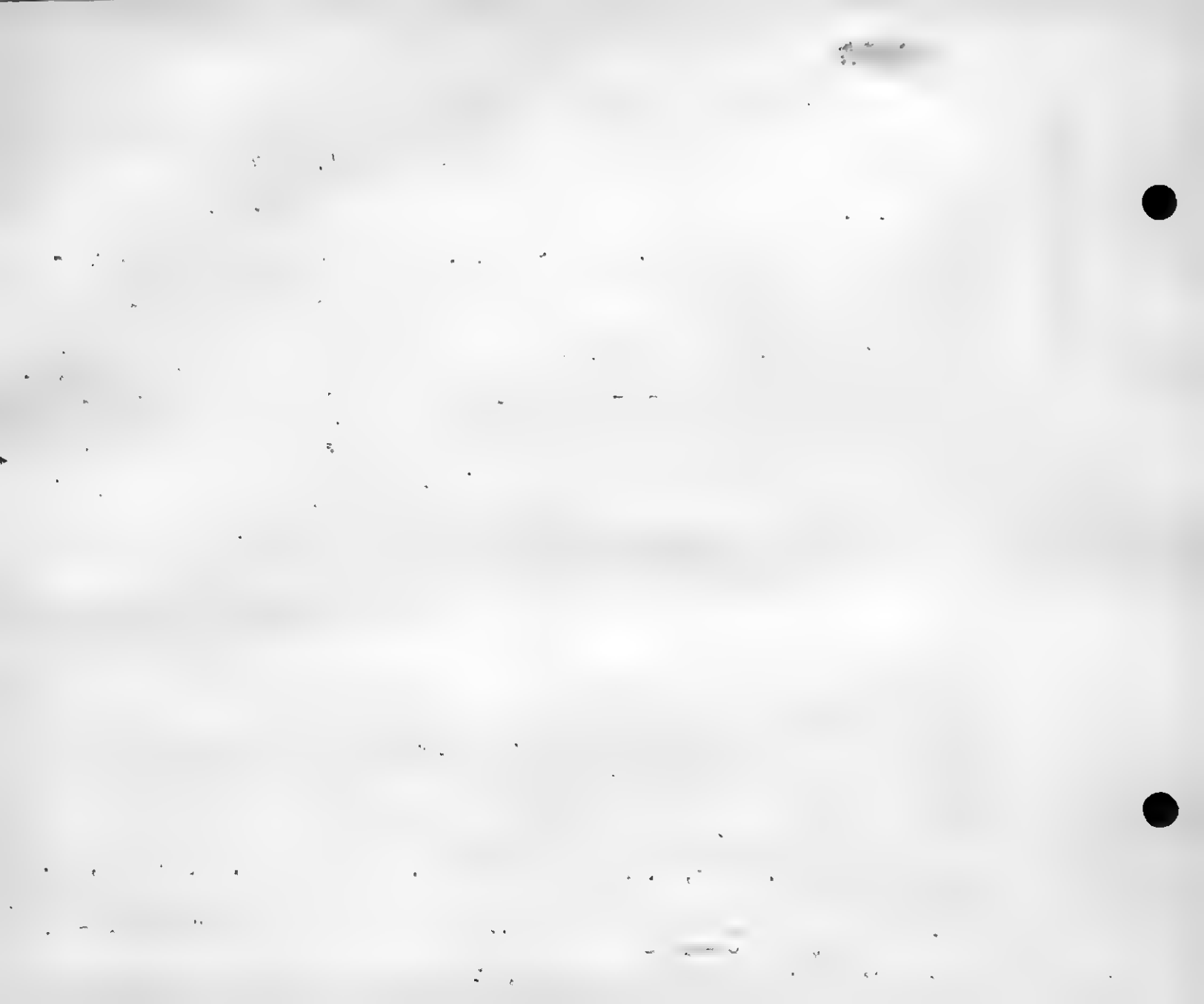


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Julia Beatrice Rhodes			2a. DATE OF DEATH Month May Day 23 Year 1968		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH October 11, 1919		6. AGE (In years last birthday) 48 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS M.N.
7a. BIRTHPLACE (State or foreign country) Elkins, W. Va.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington		
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp. tal give street address) Washington County Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. CITY OR TOWN Washington	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 35 West Side Ave.		
14. FATHER'S NAME First William Middle Robert Last Patterson	15. MOTHER'S MAIDEN NAME First Emma Middle May Last Moss		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		
16b. SOCIAL SECURITY NO. 216-14-5886	17. INFORMANT Address Hagerstown, Md. Mrs. Mary Jo Kretzer 243 West Side Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Stem Hemorrhage + 301 DUE TO, OR AS A CONSEQUENCE OF (b) Subarachnoid Hemorrhage + 330X DUE TO, OR AS A CONSEQUENCE OF (c) Rupture of anterior communicating artery 48 hr					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) arterial arteriosclerosis					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from May 24, 1968 to May 24, 1968 , that (I) (we) last saw the deceased alive on May 22, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Edson B. Moody	DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) Edson B. Moody, M.D.	22e. ADDRESS 363 S. Cleveland Ave. Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/26/68	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown-Washington-Md.		
24. FUNERAL DIRECTOR Wm. C. Hoot	ADDRESS Rest Haven Funeral Chapel Hagerstown, Md.	25a. REC'D BY REGISTRAR DATE MAY 27 1968	25b. REGISTRAR'S SIGNATURE William C. Hoot		



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department and Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

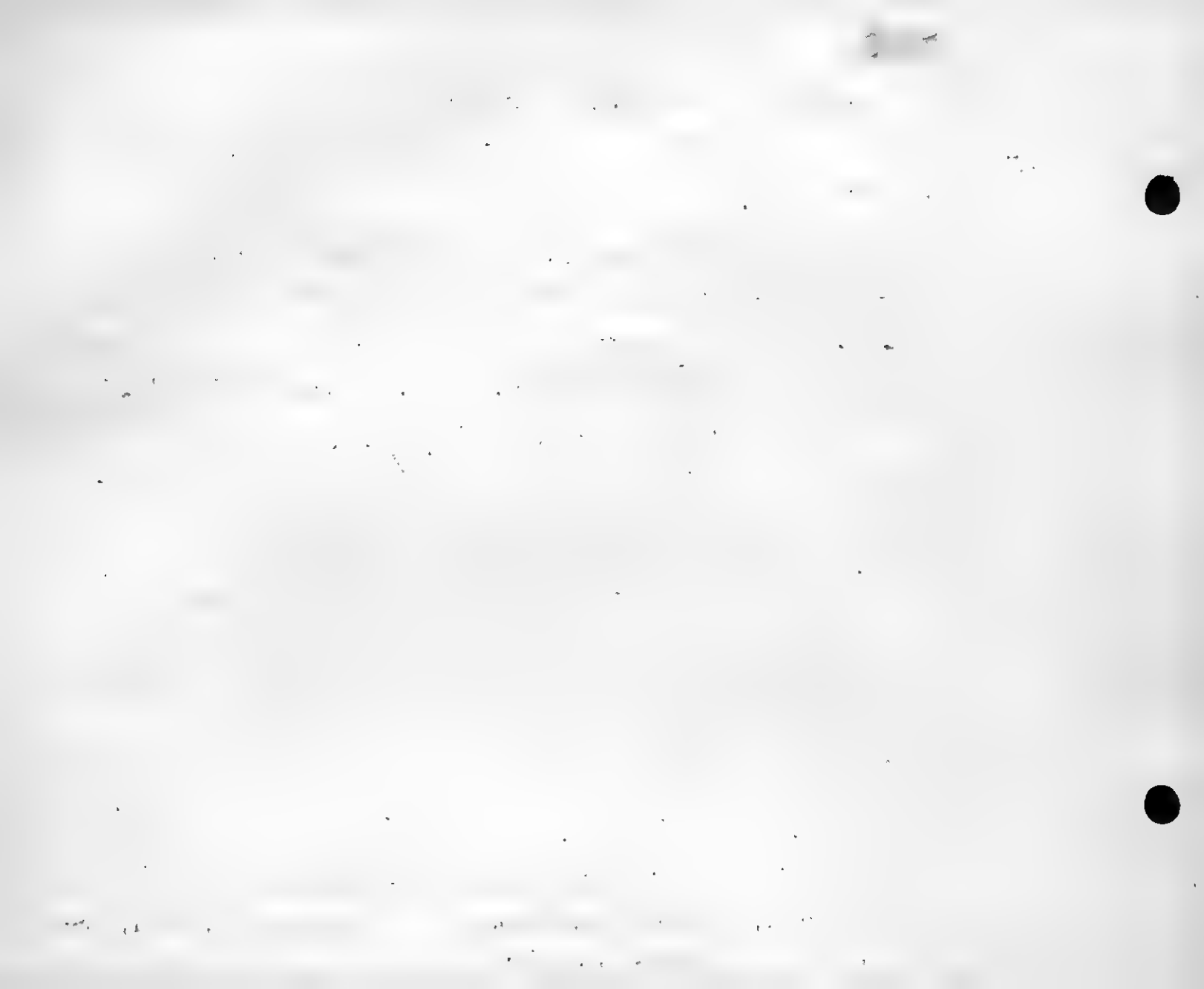
1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH	Month	Day	Year	2b. HOUR
Hettie				Runyon	ESTIMATED	5	12	1968	6:30 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years)	7. UNDER 1 YEAR	8. UNDER 24 HRS	2c. DATE PRONOUNCED DEAD		Month	Day
F	W	3/24/1913	55 YRS	MONTHS	DAYS	5	12	1968	7:25 P.M.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
VIRGINIA		U.S.A.				WASHINGTON			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
HIGHFIELD		F. RICHIE ACCESS RD		HOUSEWIFE		HOME			
13a. USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INS DE CITY LIMITS?		13e. STREET AND NUMBER	
VIRGINIA		AGUSTA		STAUNTON		YES <input type="checkbox"/> NO <input type="checkbox"/>		D. STREET.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO		17. INFORMANT	
John		LIZZIE		NO				FRANK P. HUPMAN	
								ADDRESS STAUNTON VA	
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Basal skull fracture									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
CAUSE OF DEATH		6:30 P.M. 5/12/68		CAR left road hit concrete block Horse					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Road		Rt 810 Ridge Rd.		WASH		MD	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		22b. DATE SIGNED		CHIEF MEDICAL EXAMINER					
EXAMINER'S NAME (Type)		5/12/68		ASSISTANT MEDICAL EXAMINER					
Howard N. Weeks				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
				ADDRESS (Street, city, town, or county)					
				580 Div Hwy N. Staunton VA					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		23e. REGISTRAR'S SIGNATURE	
Burial		4/15/68		HEADWATERS CEM.		HEADWATERS		DATE MAY 15 1968	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
W. J. Herment, Hagerstown, Md									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Bernard Washington Sanders			2a. DATE OF DEATH Month May Day 9 Year 1968			2b. HOUR M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH July 22 1913		6. AGE (In years last birthday) 54 YRS.		F UNDER 1 YEAR MONTHS 9 DAYS 17		IF UNDER 24 HRS HOURS MIN. 	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md					
10. CITY OR TOWN OF DEATH Hagerstown RFD #2			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hagerstown RFD #2			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Attendant Gas Station			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Maryland COUNTY Washington			13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Hagerstown RFD #2				
14. FATHER'S NAME First Harvey Middle Last Sanders			15. MOTHER'S MAIDEN NAME First Annie Middle Last Tracy								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 178 16 5297		17. INFORMANT Mrs. Lena M. Sanders			Address Hagerstown, Md. RFD #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 4201 (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Probable pulmonary embolus 2 mo. ago, Obesity											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost the deceased on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Wm. O. Rezzode						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) William O. Rezzode M. D.						22e. ADDRESS 145 South Prospect Street					
23a. BURIAL CREMATION, REMOVAL (Specify) Burial			23b. DATE May 12, 1968		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery			23d. LOCATION (City or Town) (County) (State) Williamsport, Wash., Maryland			
24. FUNERAL DIRECTOR Albert L. Leaf						ADDRESS Williamsport, Maryland		25a. REC'D BY REGISTRAR DATE MAY 15 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) Edward William Schuhmann			2a. DATE OF DEATH Month May Day 18 Year 1968			2b. HOUR 3:30 A.M.			
3. SEX male		4. RACE white		5. DATE OF BIRTH Sept. 9, 1883		6. AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington		Md.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp. list give street address) Wash. Co. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) machinist		12b. KIND OF BUSINESS OR INDUSTRY textile Mach			
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. CITY OR TOWN Washington		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 420 Belview Ave.			
14. FATHER'S NAME First Charles Middle Schuhmann Last Schuhmann				15. MOTHER'S MAIDEN NAME First Katharina Middle Abersfelder Last Abersfelder					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 196-03-8174		17. INFORMANT Address Marie Scott, Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Pituitary Tumor with Cerebral Edema DUE TO, OR AS A CONSEQUENCE OF (c) 234X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 234X								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 6 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Carcinoma of prostate, Hypopituitarism									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from May 11, 1968 , to May 18, 1968 , that (I) (we) last saw the deceased alive on May 11, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Charles C. Spencer, MD				DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED May 18, 1968	
22d. PHYSICIAN'S NAME (Type) Charles C. Spencer				22e. ADDRESS 145 S. Prospect St. Hagerstown					
23a. BURIAL, CREMATION REMOVAL (Specify) burial		23b. DATE 5-20-68		23c. NAME OF CEMETERY OR CREMATORY Gethsemane Cemetery		23d. LOCATION (City or Town) (County) (State) Reading, Penna.			
24. FUNERAL DIRECTOR ADDRESS Minnich Funeral Home, Hagerstown, Md.				25a. RECEIVED BY REGISTRAR DATE MAY 21 1968		25b. REGISTRAR'S SIGNATURE Judge			

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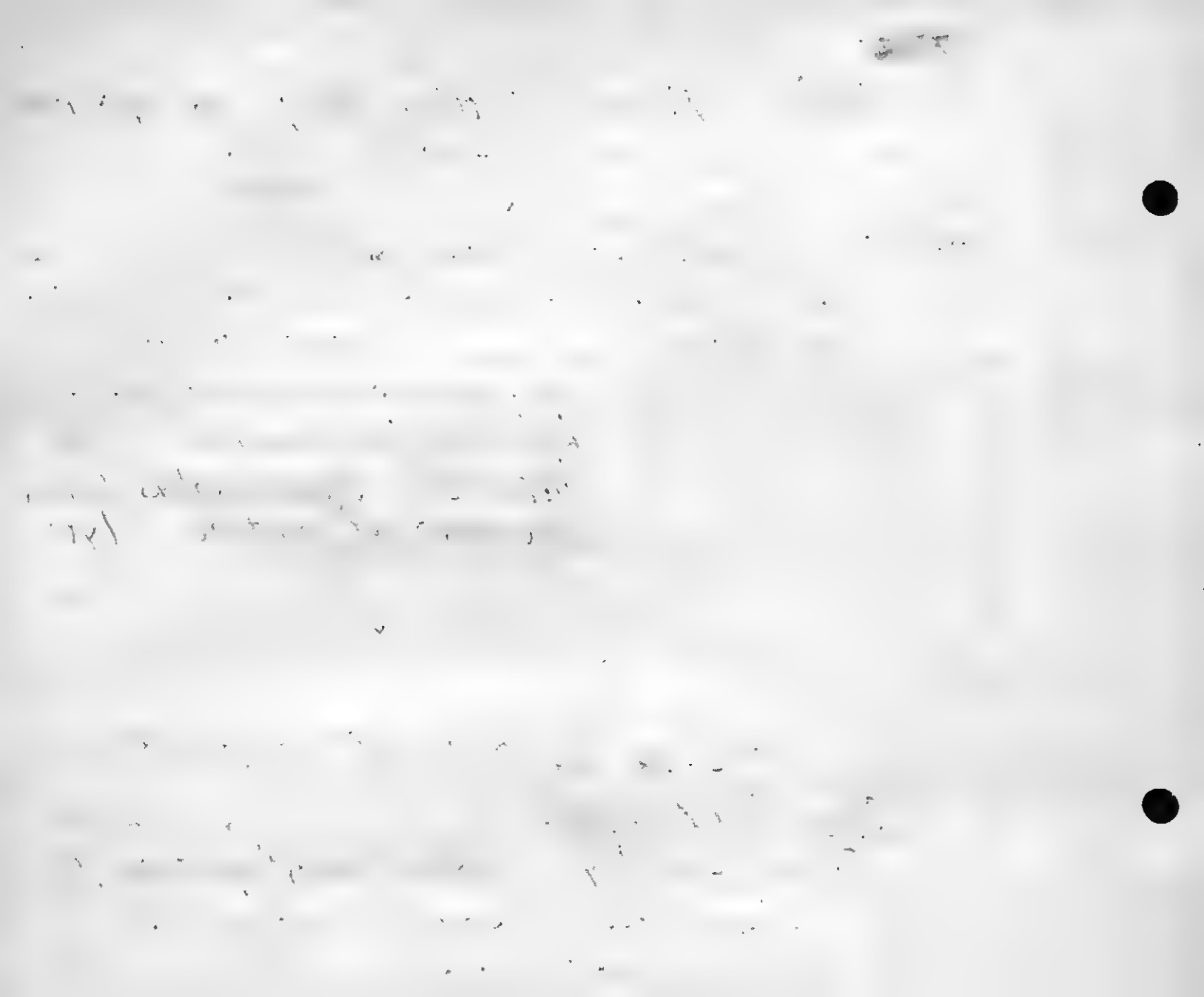
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the hospital director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 113-1
30M REV. 1-58

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) James Dustin Settles			2a. DATE OF DEATH Month May Day 28 Year 1968		2b. HOUR 12:10 PM
3 SEX male	4. RACE white	5. DATE OF BIRTH 3-22-1892		6 AGE (In years last birthday) 76 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH WASHINGTON Md.		
10. CITY OR TOWN OF DEATH HAGERSTOWN	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. USUAL RESIDENCE (Where deceased lived, if institution on, Residence before admission) STATE Md.	13b. COUNTY Wash.	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 428 W. Washington, St.	
14. FATHER'S NAME First Middle Last George Settles		15. MOTHER'S MAIDEN NAME First Middle Last Catherine Hammack			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17 INFORMANT Address Mr. James W. Settles Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 185x Lobular pneumonia DUE TO, OR AS A CONSEQUENCE OF 3d Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic carcinomatous DUE TO, OR AS A CONSEQUENCE OF 6mon (c) Carcinoma of prostate 1yr			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1111					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 5-9 , 19 68 , to 5-28 , 19 68 , that (I) (we) last saw the deceased alive on 5-28 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Edwin G. Riley MD		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 5-28-68	
22d. PHYSICIAN'S NAME (Type) Edwin G. Riley		22e. ADDRESS 1500 Penna, Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-31-1968	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 31 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR M
Gordon. Clarence Shifflett						May 2, 1968			
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
male		white		Aug. 16, 1920		47 YRS			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9 COUNTY OF DEATH	
Maryland		USA						Washington	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY
Hagerstown			Wash. Co. Hospital			sheet metal			sand blast
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES NO		13e STREET AND NUMBER
Md.			Wash.		Hagerstown		YES		213 Woodpoint Ave.
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME First Middle Last			
Emory Shifflett						Nettie Sullivan			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war and dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT Address				
yes			213-12-7304		Clara Mae Shifflett, Hagerstown, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>583x</u> <u>Cremia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) <u>Chromolonephritis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>2 mo?</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES NO		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES			
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While Not while at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>5/2</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>5/2/68</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>William O. Ruppel MD</u>					ATTENDING PHYSICIAN DEGREE			22c DATE SIGNED <u>5/9/68</u>	
					MED. DIRECTOR			STAFF PHYSICIAN	
22d PHYSICIAN'S NAME (Type)					22e ADDRESS <u>1455 - Poplar St</u>				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
burial		5-5-68		Rest Haven Cemetery			Hagerstown, Md.		
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE		
Minnich Funeral Home, Hagerstown, Md.					MAY 7 1968		<u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)
30M REV. 7-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) F. Bruce (F. Bruce Smith) Smith			2a. DATE OF DEATH Month MAY Day 26 Year 1968		2b. HOUR 3:10 A.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH Dec. 5, 1957		6. AGE (In years last birthday) 10 YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Cumberland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON	
10. CITY OR TOWN OF DEATH HAGERSTOWN	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Student		12b. KIND OF BUSINESS OR INDUSTRY School
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 602 Shriver Ave.
14. FATHER'S NAME First William Middle G. Last Smith		15. MOTHER'S MAIDEN NAME First Dorothy Middle L. Last Mullan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Father Mr. William G. Smith, Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Degeneration of cerebral cortex CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk 2 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 355X					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 9-11 , 19 67 , to 5-26 , 19 68 , that (I) (we) lost the deceased alive on 5-25 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Edwin G. Riley M.D.				22c. DATE SIGNED 5-26-68	
22d. PHYSICIAN'S NAME (Type) Edwin G. Riley				22e. ADDRESS 1500 Penna, Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE May 29, 1968	23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE MAY 29 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

2.

3. The second part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

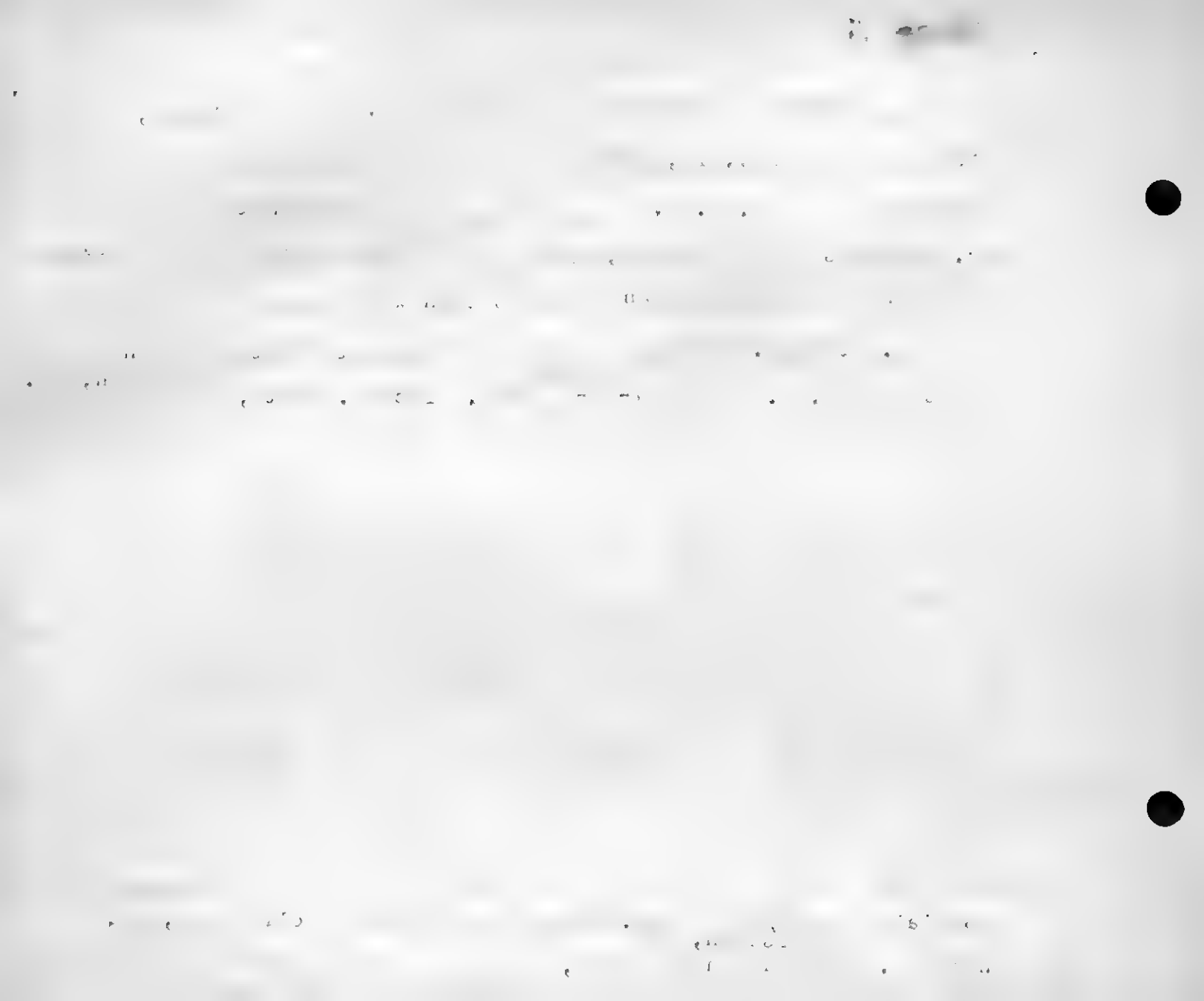
4. The third part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year		2b. HOUR 19 685:10	
MEHRLE DOWNIN SMITH, SR.									
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 1 YEAR MONTHS DAYS	8 IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR	
Male	White	Nov. 20, 1899	68 YRS			May 2, 1968		15	
7a. BIRTHPLACE (State or foreign country)		7b. CIT. ZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md	
Maryland		U. S. A.				Washington			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Nr. Cearfoss			Cearfoss Pike			Electrician		Retired	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER		
Maryland			Washington		Hagerstown	R #4	None		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Dr. Alvey J. Smith			Harriet Bertha Downin						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS				
yes			W. W. #1 217-10-		Mrs. Alice T. Smith, R #4 Hagerstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Crushed chest 510-7 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
5:10 P.M. 5/2/68			Head on auto-auto collision						
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21b. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F. No		City or Town		County State	
Rt. 58		Rt. 58		Hagerstown		Wash.		Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 5/3/68			
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Howard N. Weeks, M.D.		580 Northern Ave., Hagerstown, Md.				ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5/5/68		St. Marks Lutheran Cem		Wolfsville, Md.			
24. FUNERAL DIRECTOR Hagerstown, Md				ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE	
Andrew K. Coffman Funeral Home, Inc						MAY 7 1968		Charles J. J...	



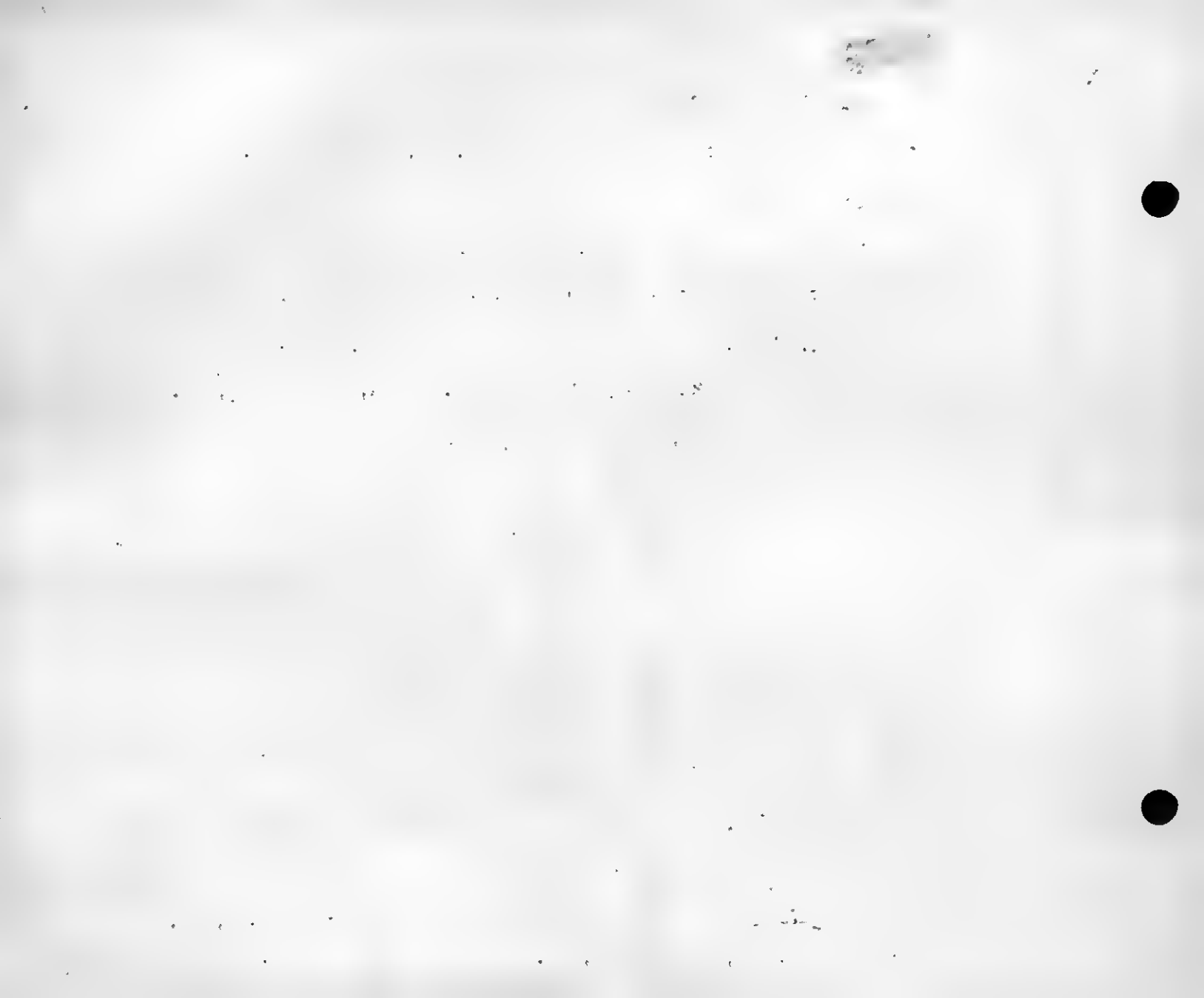
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1, 2, 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Melvin Paul Smith			2a. DATE OF DEATH Month May Day 5 Year 1968			2b. HOUR 8:40 M	
3. SEX male		4. RACE white		5. DATE OF BIRTH Sept. 22, 1912		6. AGE (In years lost birthday) 55 YRS.	
7a. BIRTHPLACE (State or foreign country) Illinois		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. Co. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired.) plumber		12b. KIND OF BUSINESS OR INDUSTRY plumbing	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Smithsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER RFD 2							
14. FATHER'S NAME First Middle Last Silas M. Smith				15. MOTHER'S MAIDEN NAME First Middle Last Minnie Wolfe			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 220-10-3560		17. INFORMANT Address Ruth N. Smith, Smithsburg, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours 4 years 3 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 42-1							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4-23, 1955 , to 5-5, 1968 , that (I) (we) last saw the deceased alive on 4-29, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Charles F. Hess				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5-6-68	
22d. PHYSICIAN'S NAME (Type) Charles F. Hess, M.D.				22e. ADDRESS Smithsburg, Maryland 21763			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 5-8-68		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		23d. LOCATION (City or Town) (County) (State) Smithsburg, Md.	
24. FUNERAL DIRECTOR ADDRESS Minnich Funeral Home, Hagerstown, Md.				25a. REC'D BY REGISTRAR DATE MAY 8 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



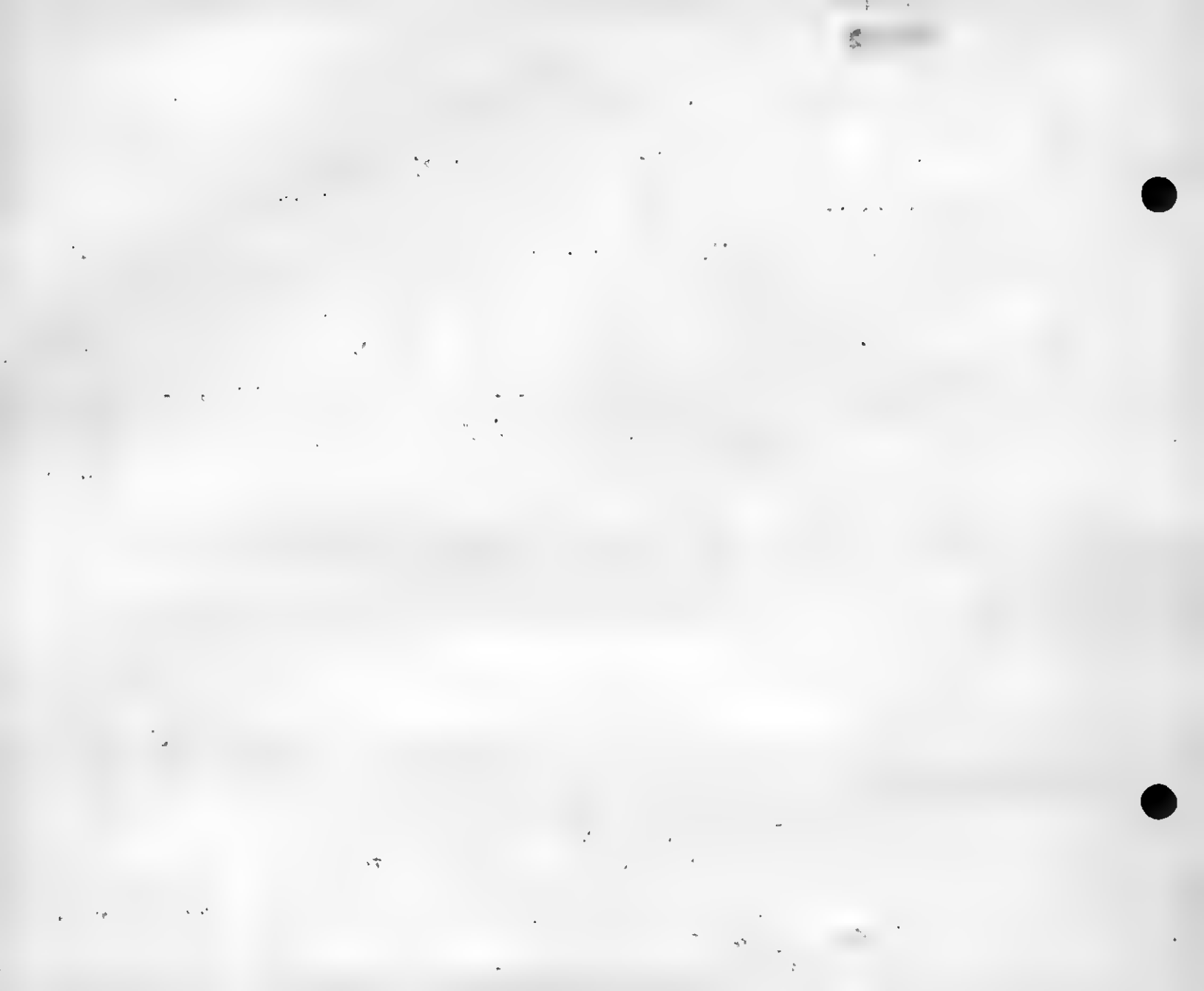
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 413 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First <u>Gary</u> Middle <u>Lynn</u> Last <u>Smoot</u>			2a. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1968</u>		2b. HOUR M <u></u>
3. SEX <u>Male</u>	4. RACE <u>White</u>		5. DATE OF BIRTH <u>May 18, 1968</u>		6. AGE (In years last birthday) YRS. <u></u> MONTHS <u></u> DAYS <u></u>
7a. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <u>Washington</u>		Md.			
10. CITY OR TOWN OF DEATH <u>Hagerstown</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Washington County Hospital</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>None</u>	
12b. KIND OF BUSINESS OR INDUSTRY <u>None</u>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Washington</u>		13c. CITY OR TOWN <u>Sharpsburg</u>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <u>R # 1</u>			
14. FATHER'S NAME First <u>Russell</u> Middle <u>Ray</u> Last <u>Smoot</u>			15. MOTHER'S MAIDEN NAME First <u>Viola</u> Middle <u>Clondine</u> Last <u>Shanholtz</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <u>No</u>		16b. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>R.R. Smoot R # 1 Sharpsburg, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Atelectasis - severe</u> <u>7720</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Subacute Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>24 hrs.</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION <u></u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u></u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>y</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>5/18</u> , 19 <u>68</u> , to <u>5/19</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>5/19</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Richard A. Young</u>		22c. DATE SIGNED <u>5/20/68</u>		22d. PHYSICIAN'S NAME (Type) <u>Richard A. Young</u>	
22e. ADDRESS <u>Hagerstown Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>5/21/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	
23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>					
24. FUNERAL DIRECTOR <u>Wm. G. Smith</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
25c. ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		DATE <u>MAY 22 1968</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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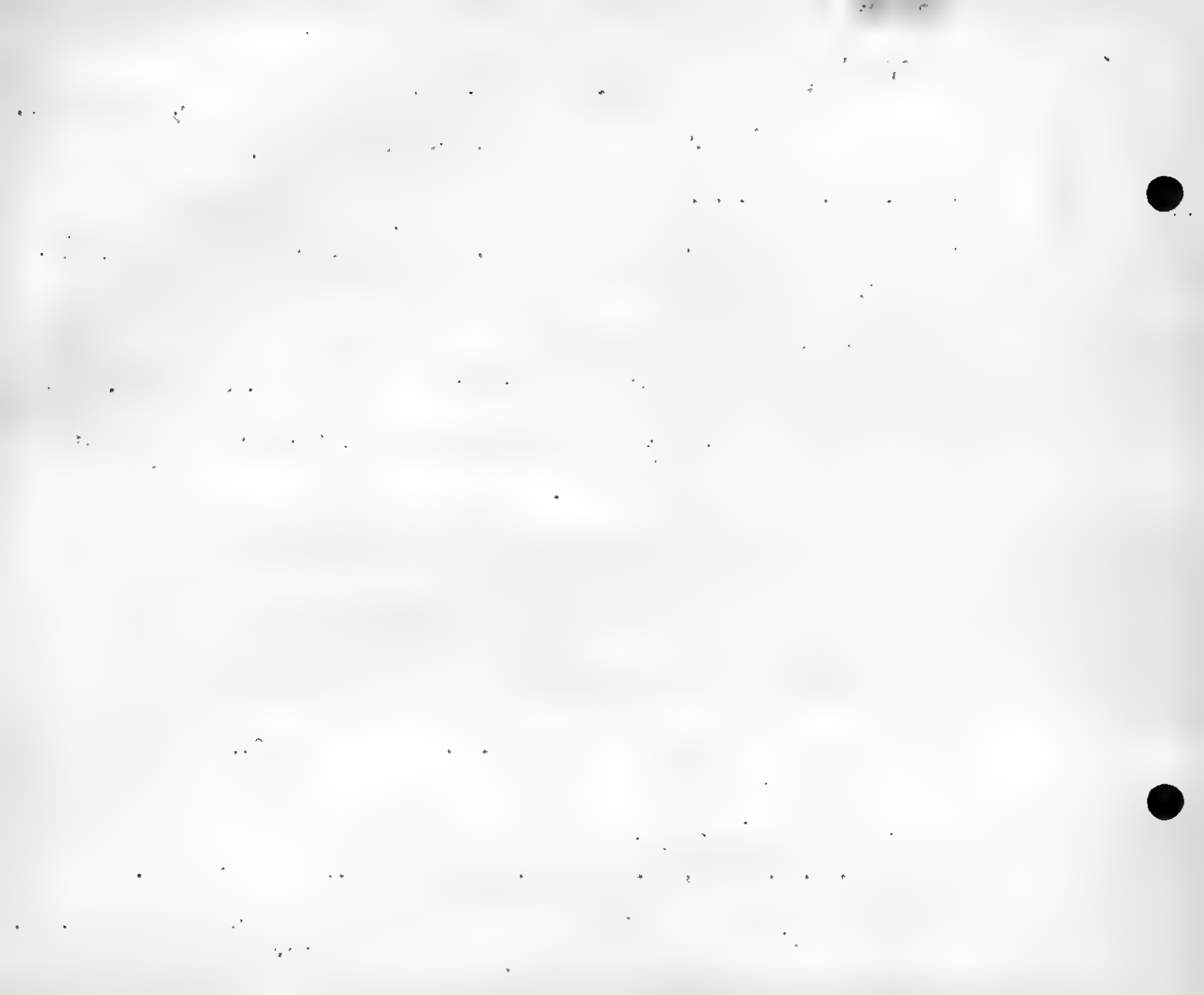
VR A15 (4)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

Item 13a, File 101 6/5/68

1. DECEASED NAME (Type or print) Harry Reasner Spoonhour			2a. DATE OF DEATH Month May Day 30 Year 1968		2b. HOUR 10 P.M.
3 SEX Male	4. RACE White	5. DATE OF BIRTH Aug. 24, 1891		6. AGE (In years lost birthday) 76 YRS.	
7a. BIRTHPLACE (State or foreign country) Waynesboro Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
7c. COUNTY OF DEATH Washington		9. COUNTY OF DEATH Washington			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hospital Garlock Memorial Conv.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Tool Maker	
12b. KIND OF BUSINESS OR INDUSTRY Crown, Seal & Cork		13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Baltimore	
13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Unknown	
14. FATHER'S NAME First Charles Middle L. Last Spoonhour			15. MOTHER'S MAIDEN NAME First Jennie Middle Reasner		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 212-09-7875		17. INFORMANT Address Miss Sarah Jane Spoonhour, Columbus, Ohio	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio Vascular Disease 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Hemiplegia Lt. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years Several years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Sept. 5, 1965 , to May 30, 1968 , that (I) (we) last saw the deceased alive on May 20, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE A. E. W. Ditto, Jr.				22c. DATE SIGNED May 31, 1968	
22d. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.				22e. ADDRESS 215 W. Washington St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/2/68		23c. NAME OF CEMETERY OR CREMATORY Green Hill	
23d. LOCATION (City or Town) (County) (State) Waynesboro, Franklin Co. Pa.					
24. FUNERAL DIRECTOR ADDRESS Walter Y. Grove Waynesboro Pa.				25a. REC'D BY REGISTRAR DATE JUN 3 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

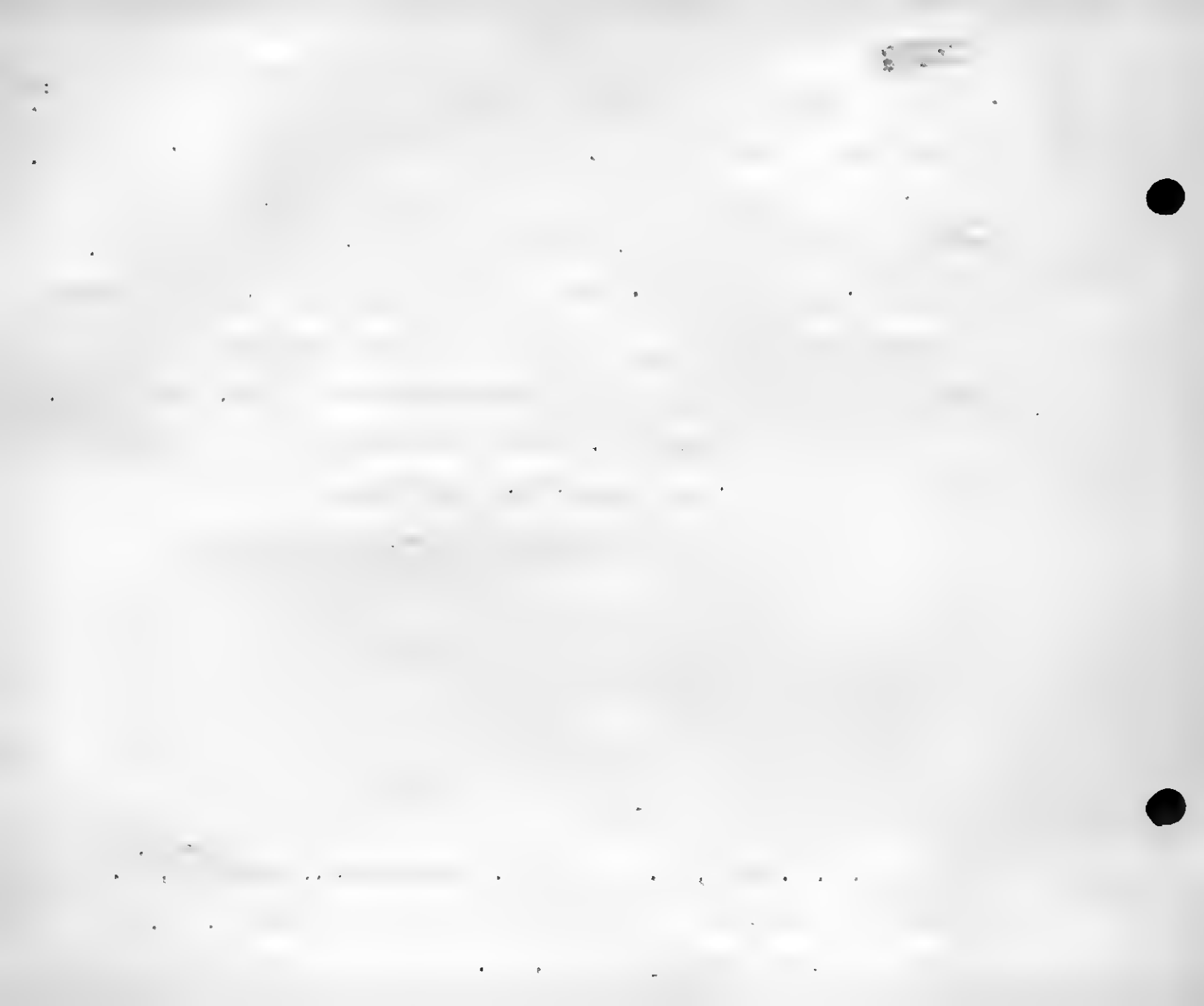


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-9. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

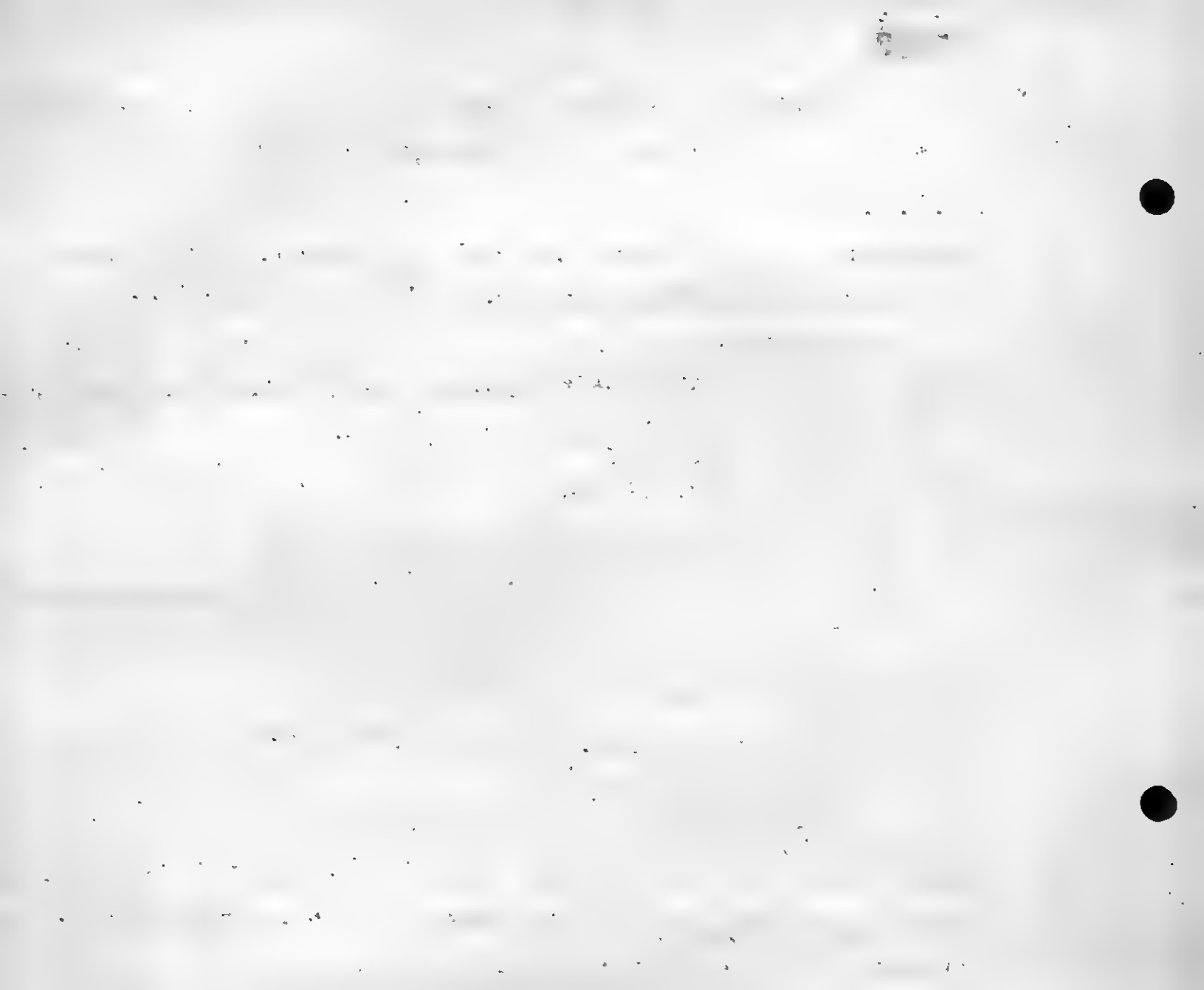
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			Month Day Year	
Thelma Lorraine Springer						DATE KNOWN OF DEATH MATED			5-7 1968	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 24 HRS MONTHS	YEAR	8 IF UNDER 24 HRS DAYS	9 HOURS	10 MIN	2c DATE PRONOUNCED DEAD	
female	white	9-6-26	41 YRS						Month 5 Day 7 Year 1968	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				2d HOUR
Md.		USA				Washington				8:55 P.M.
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
Williamsport			317 S. Conococheague			clerk			Dept. Store	
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INS DE CITY (MM/YY)	
Md.			Wash. Williamsport			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			317 S. Conococheague	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Chester Hawbecker			Elsie Pensinger							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17. INFORMANT ADDRESS				
no						Elsie Hawbecker Clear Spring, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Aneurysm Rt. Middle Cerebral Artery, Ruptured										Several minutes
DUE TO, OR AS A CONSEQUENCE OF										
(b) C Subarachnoid Hemorrhage, Massive										
DUE TO, OR AS A CONSEQUENCE OF										
(c) Pulmonary Congestion & Edema, Aspiration Of										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
Vomitus										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?				
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
			HOUR A.M. P.M. 19							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b DATE SIGNED				
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER			May 9, 1968				
Dr. E. W. Ditto, Jr.			DEPUTY MEDICAL EXAMINER							
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)	
burial			5-11-68			Rose Hill Cemetery			Hagerstown, Md.	
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE	
Minnich Funeral Home Hagerstown, Md.						DATE MAY 13 1968			Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
			Melvin	Richard	Stone	May 8 1968		6:56 P.M.	
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male		White		October, 30, 1919		48 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			
Wash. Co. Md.		USA				Washington Md.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown		Washington Co. Hospital		Diet milk, Mfg. Butter		Creamery			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		102 Elizabeth St.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
			Ulysses	Simpson	Grant Stone				Nora Mae Burrall
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17 INFORMANT				
No			214-14-6296		Mr. Millard Stone 36 Madison Ave. Hagerstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Tumor								2 yrs.	
DUE TO, OR AS A CONSEQUENCE OF (b) Bronchogenic Carcinoma of Lung								1 yr.	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cirrhosis of Liver.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
None				YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from May 1, 1968, to May 8, 1968, that (I) (we) saw the deceased alive on May 8, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				22c. DATE SIGNED					
J. H. Beachley, M.D.				5/19/68					
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
J. H. Beachley				Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5/11/68		Rest Haven Cemetery		Hagerstown-Washington Md.			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm. G. Horst				Rest Haven Funeral Chapel Hagerstown, Md.		DATE MAY 13 1968		J. H. Beachley, Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 4, 5, 6, 7, and 8, and place them in the envelope provided. The envelope should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 118 (21)
30M REV 1/768

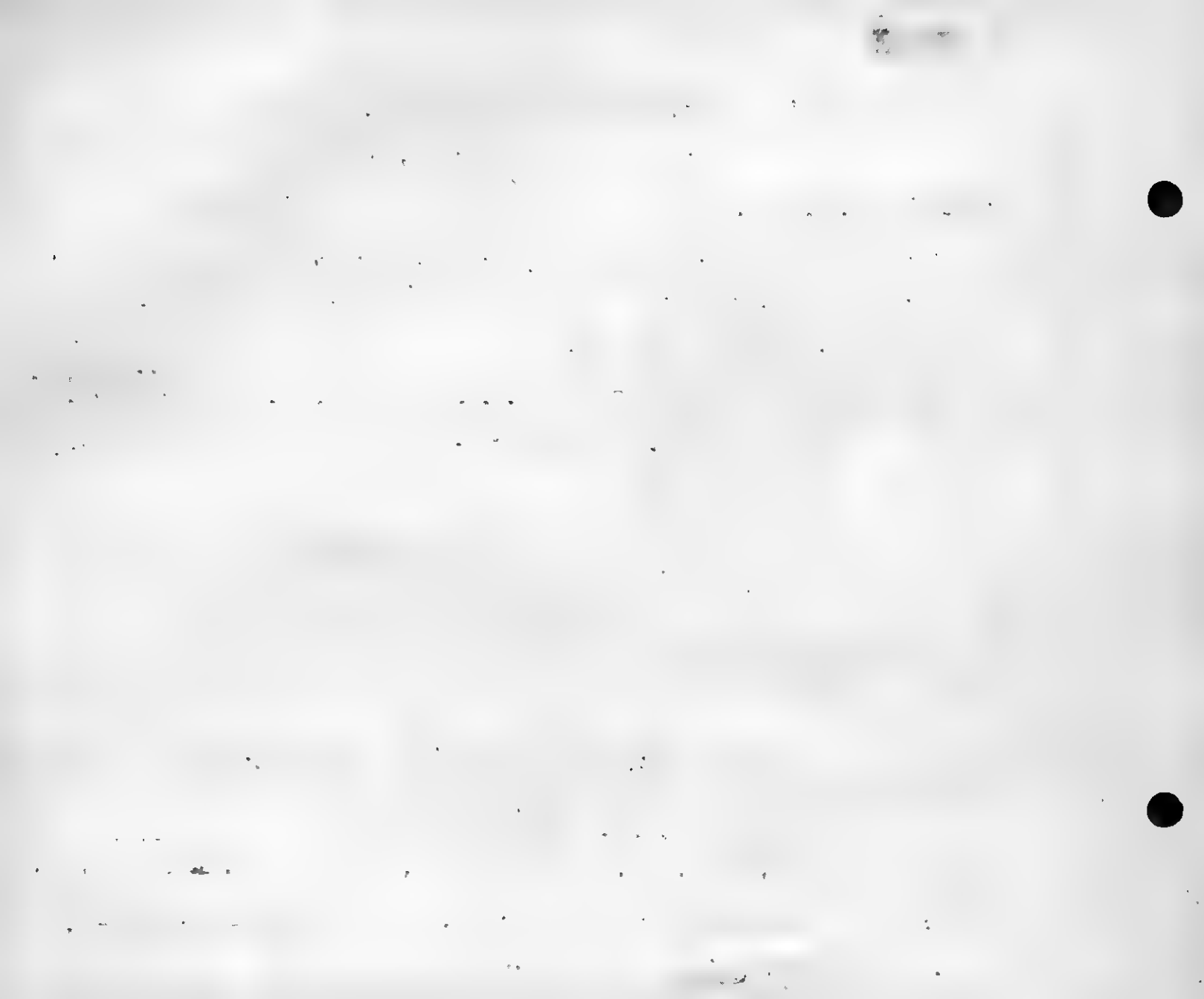
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Ernest Elsworth Stottlemeyer, Sr.			2a DATE OF DEATH Month May Day 16 Year 1968			2b. HOUR M 					
3 SEX Male		4 RACE White		5 DATE OF BIRTH August 9, 1903		6 AGE (In years last birthday) 64 YRS		7 UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN. 	
7a. BIRTHPLACE (State or foreign country) Frederick Co., Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8- MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.					
10. CITY OR TOWN OF DEATH Hagerstown		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Watchmaker				12b. KIND OF BUSINESS OR INDUSTRY Watches			
13a USUAL RESIDENCE (Where deceased lived, if institution Res. dence before admission) Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1033 Florida Ave.			
14 FATHER'S NAME First Martin Middle Luther Last Stottlemeyer			5 MOTHER'S MAIDEN NAME First Alma Middle Mae Last Zittle			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) No (If yes give war or dates of service)					
16b. SOCIAL SECURITY NO. 214-09-2675		17 INFORMANT Address Hagerstown, Md. Mrs. E. E. Stottlemeyer, Sr. 1033 Florida Ave.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) arterial insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) chronic pulmonary emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days 10 yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Osteoporosis; Psoriasis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH: (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE, BUILDING, ETC.		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 1/1/68, 19 to May 16 1968 , that (I) (we) last saw the deceased alive on May 16 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Edson B. Moody, M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5-17-68					
22d. PHYSICIAN'S NAME (Type) Edson B. Moody, M.D.		22e. ADDRESS 363 S. Cleveland Ave. Hagerstown, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 20, 1968		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown-Washington-Md.					
24. FUNERAL DIRECTOR Rest Haven Funeral Chapel		ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE MAY 21 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

MEDICAL CERTIFICATION

(Certified by)
Fred Nisone

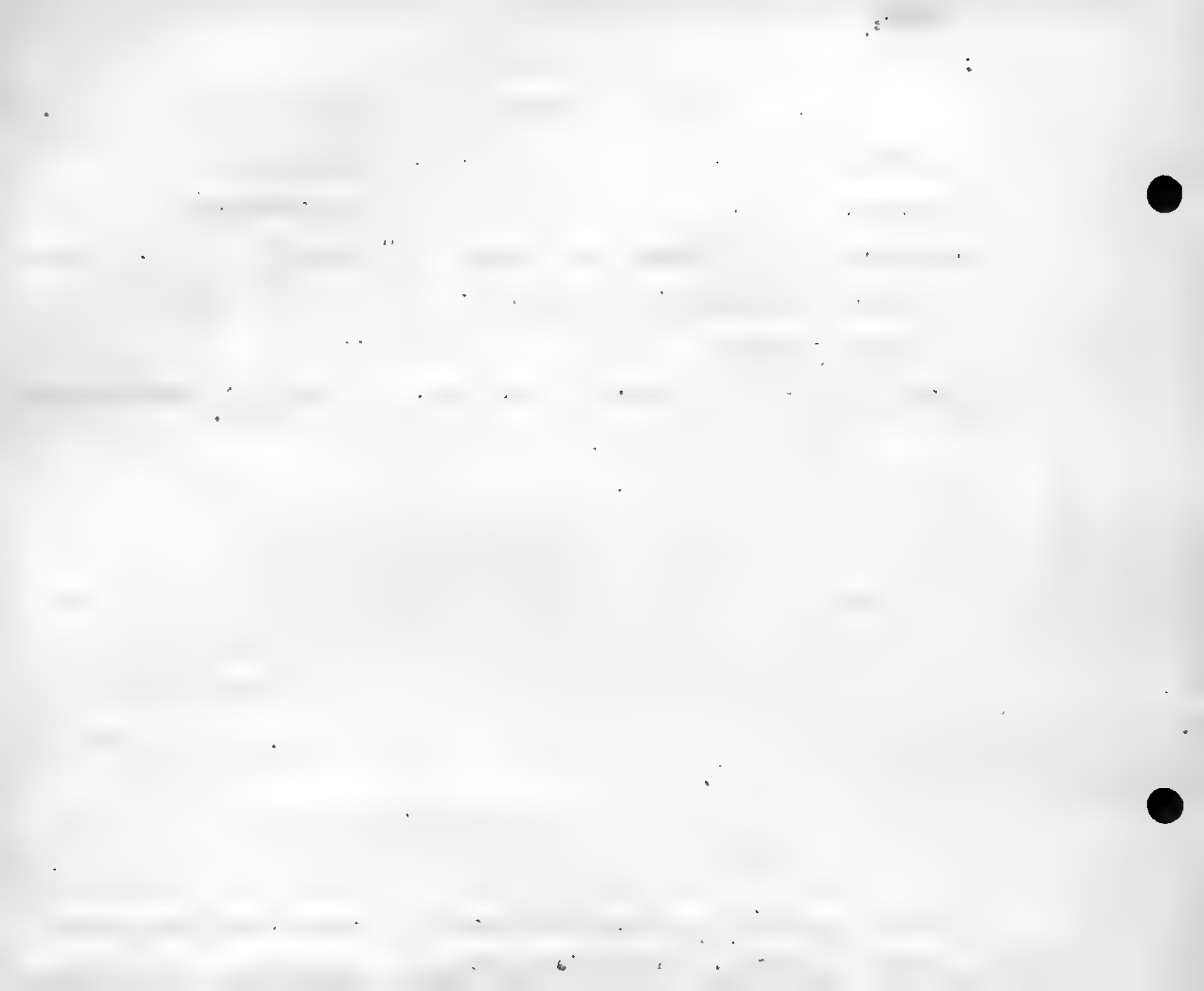
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
ANNA VIOLA SUMMER						May 19 1968			6:45 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
Female		White		June 12 1870		97 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Washington Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown		Jackson Conv Home		housewife		Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Washington		Hagerstown				46 North Ave	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Urias Bingham						Susan Miller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT Address			
No			None			Mrs Miriam H Ighbarger Hagerstown Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arterio-sclerosis - Generalized</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>10 yrs.</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>55 X</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 14, 1956</u> , to <u>May 19, 1968</u> , that (I) (we) saw the deceased alive on <u>May 16, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Lloyd A. Hoffman</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>5/20/68</u>	
22d. PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman</u>						22e. ADDRESS <u>214 N. Potomac St. Hagerstown Md</u>			
23a. BURIAL, CREMATION, REMOVAL, (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5/22/68		Rose Hill Cemetery		Hagerstown Wash Co Md			
24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>						25a. REC'D BY REGISTRAR <u>May 22 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



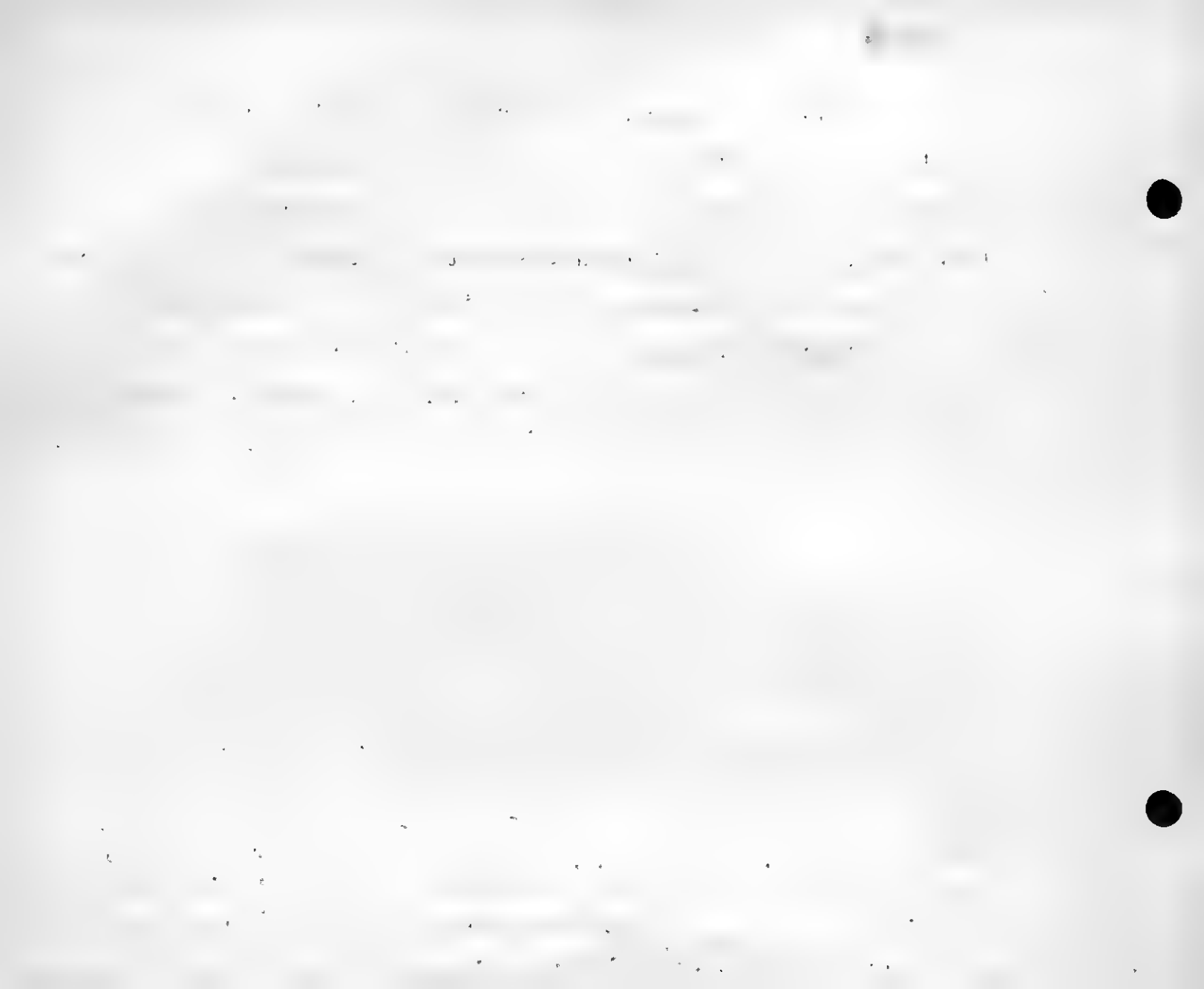
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

57698

1. DECEASED NAME (Type or print) LLOYD JAMES SWOPE			2a. DATE OF DEATH Month May Day 12 Year 1968			2b. HOUR 6 A. M.					
3 SEX Male		4 RACE White		5. DATE OF BIRTH Jan 26 1917		6 AGE (In years last birthday) 51 YRS.		7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Washington Md.		
10 CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash County Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Laborer			12b KIND OF BUSINESS OR INDUSTRY Coal Yard		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Washington		13c CITY OR TOWN Big Spring		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Boyd Road		
14. FATHER'S NAME First Raymond Middle Swope Last			15. MOTHER'S MAIDEN NAME First Virgie Middle Lowman Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (na, or unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 214-14-6406		17. INFORMANT Address R # 1 Mrs Owanda V. Swope Big Spring Md						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM STREET, FACTORY, OFFICE BUILDING ETC)		21f LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 5/9, 1968 , to 5/12, 1968 , that (I) (we) last saw the deceased alive on 5/12/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John H. Hornbaker, M.D.				22c. DATE SIGNED 5-13-68							
22d. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.				22e. ADDRESS 154 West Washington St., Hagerstown, Md. 21740							
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE		23c NAME OF CEMETERY OR CREMATORY Lutheren Cemetery		23d LOCATION (City or Town) (County) (State) Leitersburg Wash Co Md					
24. FUNERAL DIRECTOR Andrew W. Coffman				24a REC'D BY REGISTRAR W. K. Coffman				24b REGISTRAR'S SIGNATURE Charles Judge			

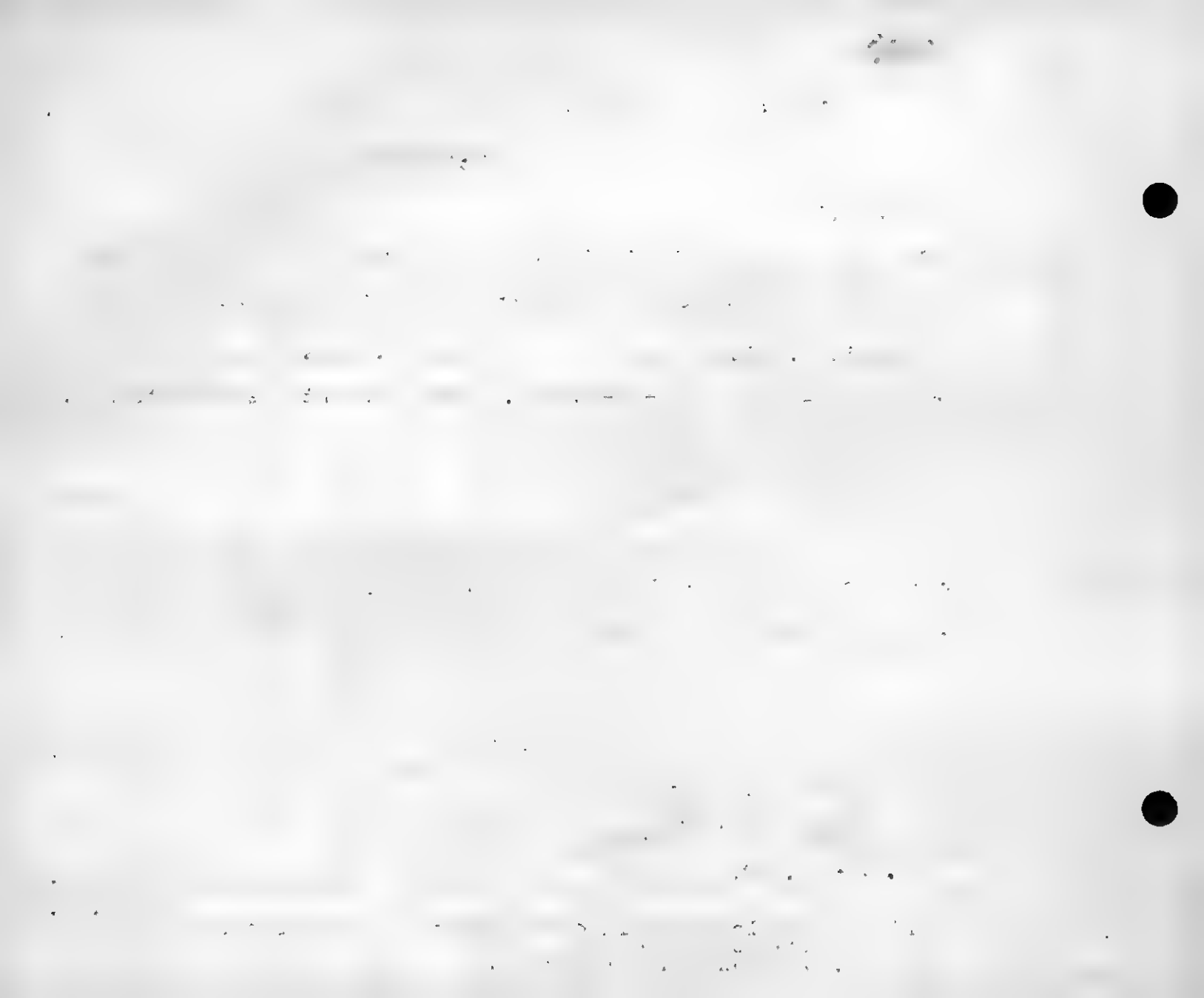


CERTIFICATE OF DEATH

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1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR A M	
Sarah Rolandus Tennant					May 13, 1968		6:35	
3. SEX F	4. RACE W	5. DATE OF BIRTH Oct. 9, 1893			6. AGE (In years last birthday) 74 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Berkeley Co. W. Va.	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.				
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY USA	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE W. Va.		13b. COUNTY Berkeley	13c. CITY OR TOWN Shepherdstown	13d. INSIDE CITY LIM TSP? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER None			
14. FATHER'S NAME First Middle Last Calvin R. Tice		15. MOTHER'S M.A.DEN NAME First Middle Last Sara E. Grosh						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No --		16b. SOCIAL SECURITY NO. 233-74-2408		17. INFORMANT Address C. Elmer Tennant Shepherdstown W. Va.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure</u> 571.9 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cirrhosis of liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks 8 months								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Stricture of sphincter of Oddi with obstruction of common duct</u>								
19a. DATE OF OPERATION May 11, 68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Obstructive jaundice			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from May 9, 1968, 19 to May 13, 1968, that (I) (we) lost the deceased alive on May 12, 1968 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>John H. Kehne</i>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED May 13, 1968				
22d. PHYSICIAN'S NAME (Type) JOHN H. KEHNE, M. D.		22e. ADDRESS 1229 Ravenswood Hts., Hagerstown, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE May 15 1968		23c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery		23d. LOCATION (City or Town) (County) (State) Shepherdstown Berkeley Co W. Va.		
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc		24a. ADDRESS Hagerstown Md		24b. REC'D BY REGISTRAR DATE MAY 15 1968		24c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR P		
CEALIE ELIAZBETH TRUMPOWER						MAY 24, 1968			5:00 PM		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH AUGUST 3, 1886		6. AGE (in years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON			Md.		
10. CITY OR TOWN OF DEATH BIG POOL		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) RURAL BIG POOL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME					
13a. USUAL RESIDENCE (Where deceased lived, if institut on admission) STATE MARYLAND		13b. COUNTY WASHINGTON		13c. CITY OR TOWN BIG POOL		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RURAL			
14. FATHER'S NAME JOHN			First	Middle	Last	15. MOTHER'S MAIDEN NAME LUCY DICKERHOFF			First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT MRS. LOLA MILLER		Address BIG POOL, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerosis heart disease 3 weeks</u> 4127 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) +											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>5/15</u> , 19 <u>68</u> , to <u>5/24</u> , 19 <u>68</u> , that (we) lost saw the deceased alive on <u>5/5</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Sidney Novenstein</u>		DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED <u>5-25-68</u>					
22d. PHYSICIAN'S NAME (Type) <u>SIDNEY NOVENSTEIN</u>		22e. ADDRESS <u>FUNKSTOWN MD</u>									
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE <u>5/27/68</u>		23c. NAME OF CEMETERY OR CREMATOR <u>PARKHEAD UNITED METHODIST</u>		23d. LOCATION (City or Town) (County) (State) <u>BIG POOL, WASH, MD.</u>					
24. FUNERAL DIRECTOR <u>Howard J. Goral</u>		HANGCOCK, MARYLAND		25a. REC'D BY REGISTRAR DATE <u>MAY 28 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

100

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ASTOR LENOX TILDEN FOUNDATION

500 FIFTH AVENUE, NEW YORK, N. Y.

1911

THE NEW YORK PUBLIC LIBRARY

ASTOR LENOX TILDEN FOUNDATION

500 FIFTH AVENUE, NEW YORK, N. Y.

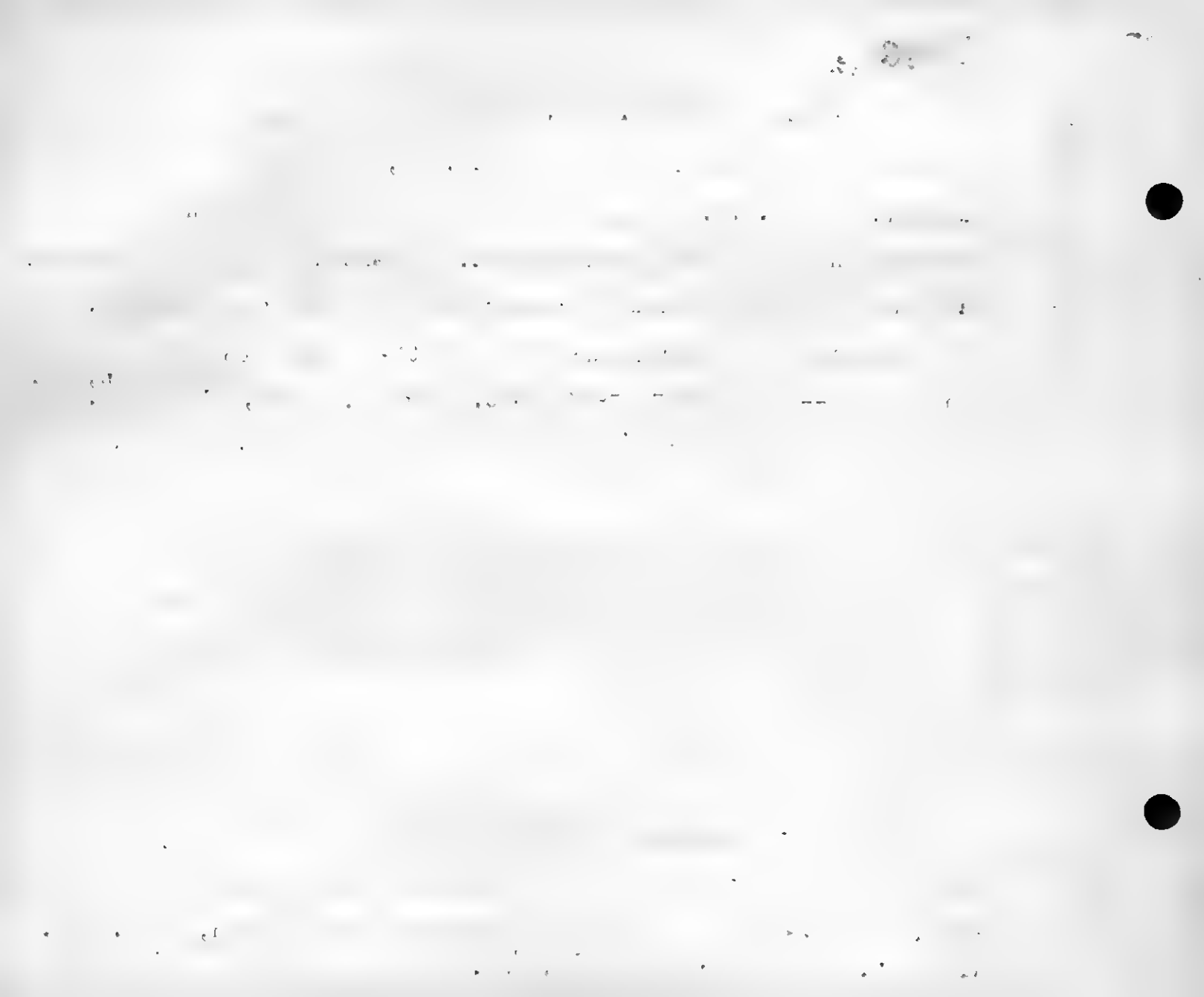
1911

THE NEW YORK PUBLIC LIBRARY
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			20. DATE OF DEATH Month Day Year			2b. HOUR
PAUL RAYMOND VALENTINE						May 5 1968			9:00A
3 SEX	4 RACE	5. DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
Male	White	Feb. 17, 1894			74 YRS				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Washington Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown		38 Devonshire Rd.			Carpenter			Retired	
13a. USUAL RESIDENCE (Where deceased admitted) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Washington		Hagerstown		YES		38 Devonshire Rd.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
William Valentine			Katie (No Record)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17 INFORMANT		Address			
no		214-09-3672		Mrs. Janet I. Jones		Hagerstown, Md. College Rd. R #3			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension Cardio Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF 4120 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ (Conditions, if any, which gave rise to immediate cause (a), storing the underlying cause last.)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 443x									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
2 d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>4/7</u> , 19 <u>64</u> , to <u>5/5</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3/1</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Elder S Hoachler M.D.</u>					DEGREE M.D.		22c. DATE SIGNED 5/6/68		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Elder S Hoachler M.D.					Hagerstown Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5/8/68		Rose Hill Cemetery		Hagerstown, Wash.		Md.	
24. FUNERAL DIRECTOR					25b. REGISTERED				
Andrew K. Coffman Funeral Home, Inc.					MAY 8 1968				
					25b. REGISTERED				
					John Judge				



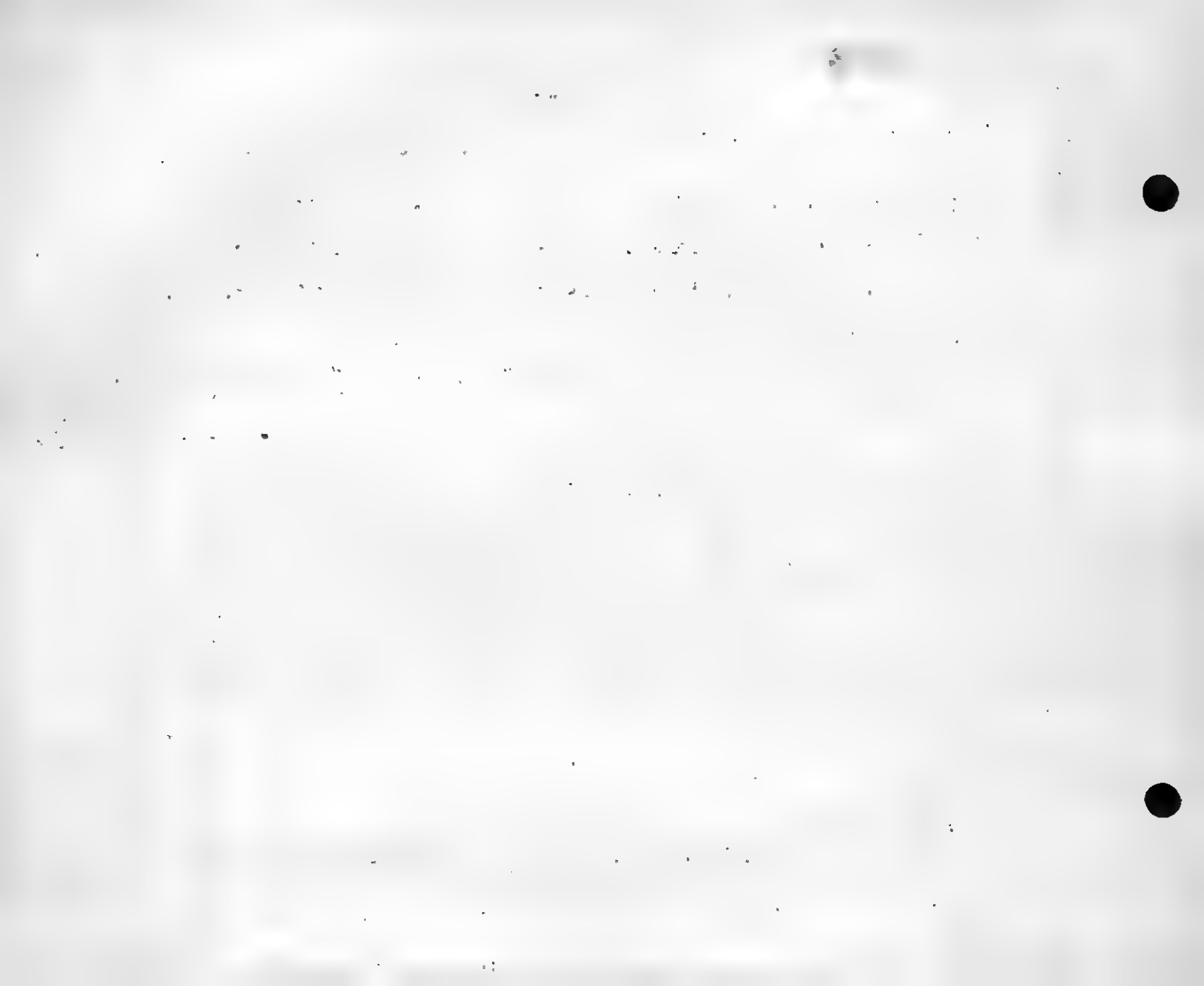
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VR A 1-64
30M REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Mabel Estelle VanMater			2a. DATE OF DEATH Month Day Year May 20 68 Year			2b. HOUR 10 P.M.			
3. SEX Female		4. RACE white		5. DATE OF BIRTH Jan. 1, 1900		6. AGE (in years last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Harpers Ferry, W. Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Washington Co. Md			
10. CITY OR TOWN OF DEATH Hagerstown, Md.		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Washington Co. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Restaurant operator		12b. KIND OF BUSINESS OR IND. STRY. Motel Rest.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2377 Penn. Ave.	
14. FATHER'S NAME First Middle Last Thomas Kauffman				15. MOTHER'S MAIDEN NAME First Middle Last Ida Staubs					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 212-14-6140		17. INFORMANT Address MELVIN D. KOLB 2377 PENNSYLVANIA AVE. HAGERSTOWN, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Dissecting Thoracic Aneurysm</i> 441.1 DUE TO, OR AS A CONSEQUENCE OF Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>451X</i> (b) <i>Generalized arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Hypertension, Essential</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 65		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 and Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>11/11</i> , 19 <i>65</i> , to <i>5/20</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>5/20</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Donald E. Martin M.D.</i>				22c. DATE SIGNED 5/20/68		22d. PHYSICIAN'S NAME (Type) DONALD E. MARTIN M.D.			
22e. ADDRESS HAGERSTOWN, MARYLAND				22f. ADDRESS 363 S. CLEVELAND HAGERSTOWN, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE 5/24/68		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Memorial		23d. LOCATION (City or Town) (County) (State) Hagerstown, Wash., Md			
24. FUNERAL DIRECTOR <i>Charles M. Judge</i>				ADDRESS Hagerstown, Maryland		25a. REC'D BY REGISTRAR DATE MAY 24 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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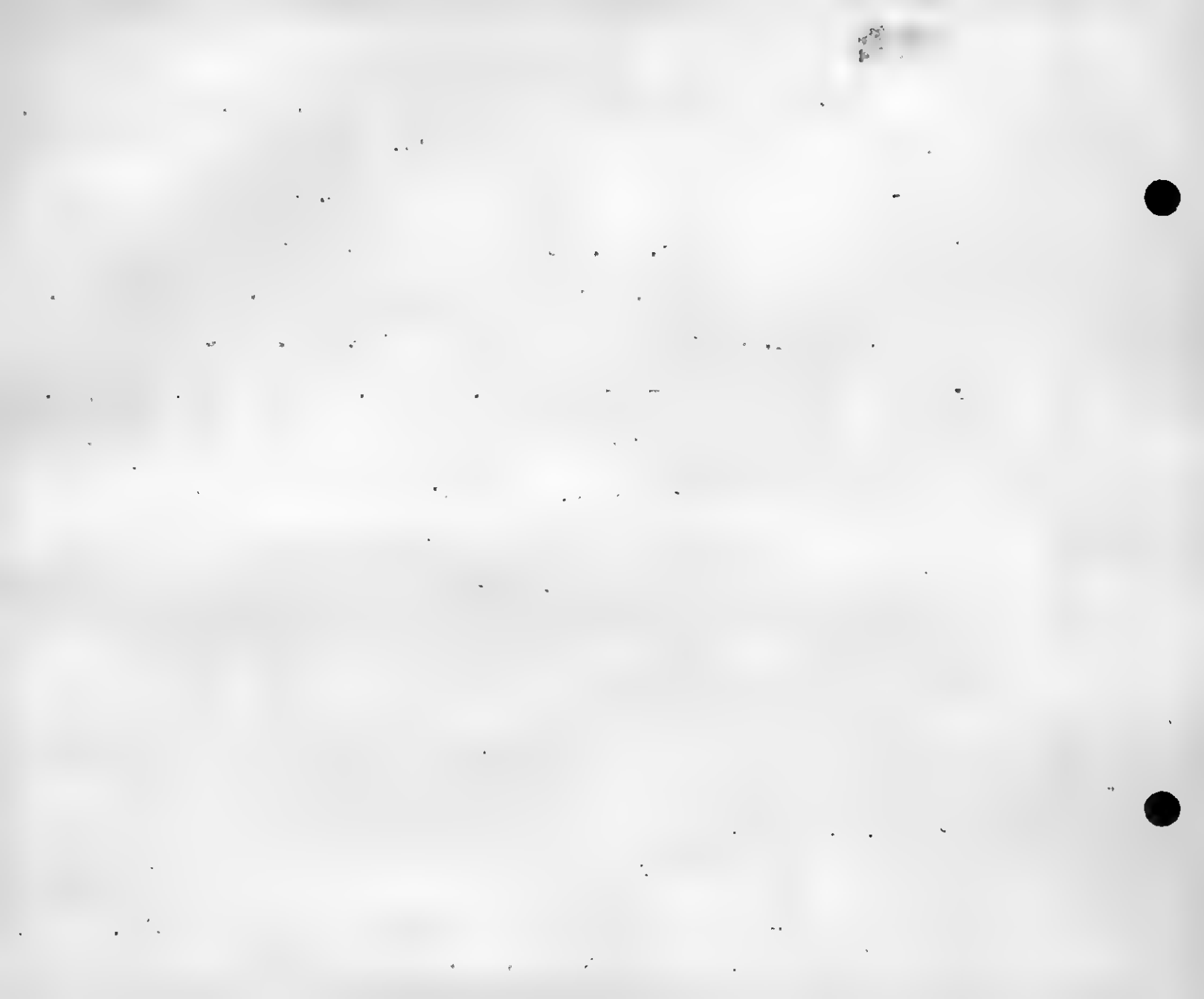
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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) First Middle Last <i>Charlotte Gleason Webster</i>			2a. DATE OF DEATH Month Day Year <i>MAY 15 1968</i>			2b. HOUR M. <i>12:30</i>			
3. SEX <i>Female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>9/20/1895</i>		6. AGE (In years last birthday) <i>72</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS M.N.	
7a. BIRTHPLACE (State or foreign country) <i>Kentucky</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Washington</i> Md.			
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Wash. Co. Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housekeeper</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Penn</i>		13b. COUNTY <i>Butler</i>		13c. CITY OR TOWN <i>MARS</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>P.O. Box 436</i>	
14. FATHER'S NAME First Middle Last <i>Willard E. Gleason</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Miriam Baker</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give year or dates of service)				16b. SOCIAL SECURITY NO <i>17</i>		17. INFORMANT Address <i>Paul F. Webster - Greencastle, Pa.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Atherosclerosis and Arterial Embolization</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>3 yr?</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 yr</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Arteriosclerotic heart disease</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>5/10</i> , 1968, to <i>5/15</i> , 1968, that (I) (we) last saw the deceased alive on <i>5/15</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>William O. Rexrode</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>May 16, 1968</i>			
22d. PHYSICIAN'S NAME (Type) <i>William O. Rexrode M. D.</i>				22e. ADDRESS <i>145 South Prospect Street</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>5/18/1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>E. Harrisburg Cem. Co.</i>		23d. LOCATION (City or Town) (County) (State) <i>Harrisburg, Penna.</i>			
24. FUNERAL DIRECTOR <i>A.E. Wimmer - Greencastle, Pa.</i>				25a. RECORD BY REGISTRAR <i>May 20 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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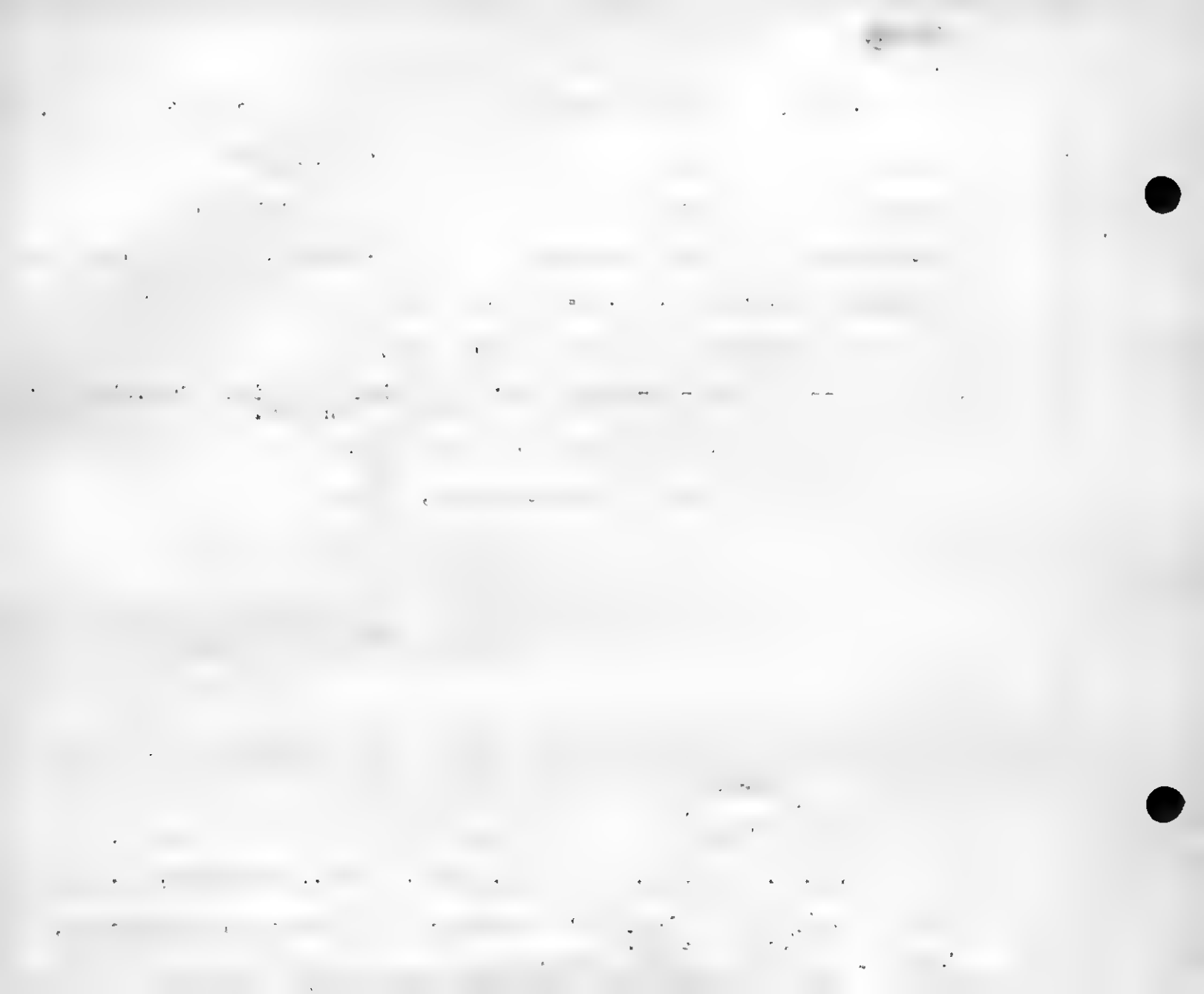
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
Mary Margaret Wetzel						May 8, 1968			10:00 P.M.		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		F. UNDER 1 YEAR		IF UNDER 24 HRS.	
female		white		April 20, 1892		76 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
Pennsylvania		USA				Washington					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown			Wash. Co. Hospital			housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland			Wash.			Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		37 E. Baltimore St.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Jacob R. Shindle			Susan A. Rice								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address		
no			214-09-7564			D Mr. Clyde S. Wetzel			Hagerstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arterio sclerotic heart disease</u>										years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										1 yr.	
(b) <u>Anger of descending colon due to voluntary colon</u>											
(c) <u>To voluntary colon</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<u>Multiple infarcts & kidneys & spleen.</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		HOUR A.M. Month Day Year P.M.									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from <u>April 22, 1968</u> , to <u>May 6, 1968</u> , that (I) (we) last saw the deceased alive on <u>May 6, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
<u>Edgar Hoachlander</u>										5/7/68	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
<u>Edgar S. Hoachlander</u>						<u>Hagerstown Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Type)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		5-9-1968		Beautiful View Cemetery		Middleburg, Md.					
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Minnich Funeral Home, Hagerstown, Md.								DATE MAY 10 1968		<u>Charles Judge</u>	



1
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) First Middle Last JOSEPH (NMN) WHITE						2a. DATE OF DEATH Month Day Year May 30 1968		2b. HOUR 11.45	
3. SEX Male		4. RACE White		5. DATE OF BIRTH March 19 1890		6. AGE (In years last birthday) 78		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Italy		7b. CITIZEN OF WHAT COUNTRY? Italy		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 426 Salem Ave			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Attendant		12b. KIND OF BUSINESS OR INDUSTRY Coal Yard		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 426 Salem Ave	
14. FATHER'S NAME First Middle Last (No Record)				15. MOTHER'S MAIDEN NAME First Middle Last (No Record)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO 214-09-1186		17. INFORMANT Mrs Catherine G. White Address 426 Salem Ave Hagerstown Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4517 IMMEDIATE CAUSE (a) Arteriosclerotic Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis, Severe DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 334X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from March 1, 1968 , to May 30, 1968 , that (I) (we) last saw the deceased alive on April 24, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE [Signature]				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED May 31, 1968			
22d. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.				22e. ADDRESS 215 W. Washington St., Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/3/68		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md.			
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc				25a. REC'D BY REGISTRAR [Signature]		25b. REGISTRAR'S SIGNATURE [Signature]			

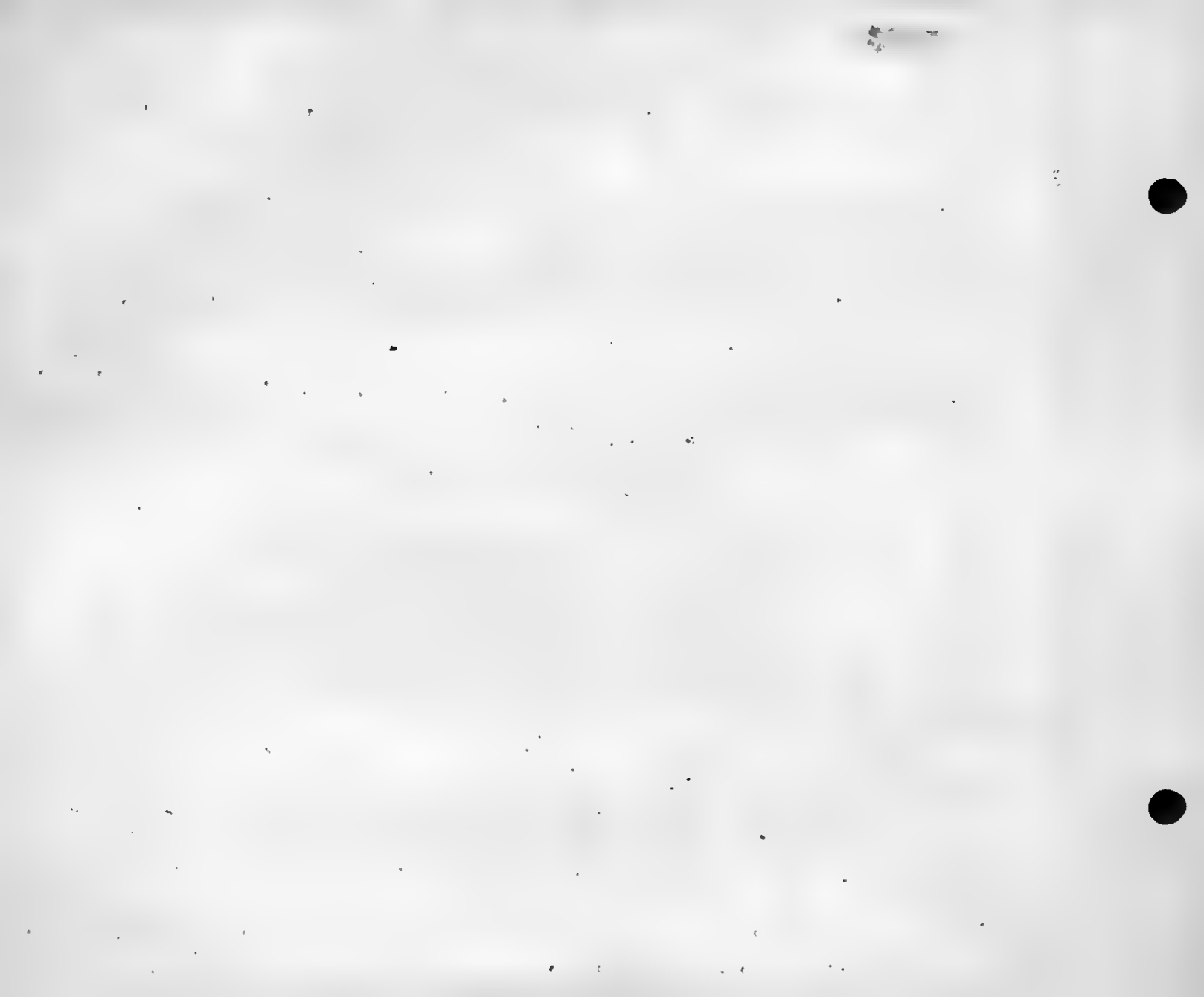


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Charlotte Bell Wilson			2a DATE OF DEATH Month Day Year May 30 1968			2b HOUR M			
3 SEX Female		4 RACE White		5 DATE OF BIRTH 1879 March 8, 1968		6 AGE (In years last birthday) 89 YRS		7 UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.			
10 CITY OR TOWN OF DEATH Boonsboro		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Fahrney Keedy Memorial Home		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b KIND OF BUSINESS OR INDUSTRY Home			
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md.		13b. COUNTY Washington		13c. CITY OR TOWN Smithsburg		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 15 East Water St.	
14. FATHER'S NAME First Middle Last Lewis J. Bell			15. MOTHER'S MAIDEN NAME First Middle Last Charlotte - Marbourg						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Madison, Wis. Mrs. Elizabeth W. Kadel, 4006 North Sherman Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intermittent cardiac vascular</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with sandlot</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yr 2 yr									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4221									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nat'lly medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Jan 10, 1968, to May 30, 1968, that (I) (we) last saw the deceased alive on May 19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE G. W. LeVan M.D.				22c. DATE SIGNED 5/31/68		22d. PHYSICIAN'S NAME (Type) G. W. LeVan M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 1, 1968		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		23d. LOCATION (City or Town) (County) (State) Smithsburg Washington Md.			
24. FUNERAL DIRECTOR Minnich Funeral Home, Smithsburg, Md.				25a. REC'D BY REGISTRAR DATE JUN 4 1968		25b. REGISTRAR'S SIGNATURE James J. Lee			



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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
07704 CERTIFICATE OF DEATH 07708												
1. DECEASED-NAME (Type or print) ^{First} GERALDINE ^{Middle} ELIZABETH ^{Last} WINTERS						2a. DATE OF DEATH ^{Month} MAY ^{Day} 9 ^{Year} 1968			2b. HOUR 7:40 AM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 4/7/1903			6. AGE (in years last birthday) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Md.						
10. CITY OR TOWN OF DEATH HAGERSTOWN			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital) WASHINGTON CO. HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of last year, see instructions.) SALES CLERK			12b. KIND OF BUSINESS OR INDUSTRY DEPT. STORE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY WASHINGTON		13c. CITY OR TOWN HAGERSTOWN		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 309 S. POTOMAC ST.			
14. FATHER'S NAME ^{First} ELMER ^{Middle} ERIE ^{Last} WINTERS				15. MOTHER'S MAIDEN NAME ^{First} NENA ^{Middle} MAY ^{Last} STONER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO. 214-09-0400		17. INFORMANT MR. EDWIN T. WINTERS			17b. ADDRESS HAGERSTOWN MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chr & acute congestive heart failure 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) none 4200												
19a. DATE OF OPERATION none		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? -				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. none 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) none								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) none		21f. LOCATION Street or R.F.D. No. -		City or Town -		County -		State -		
22a. I certify that (I) (this hospital) attended the deceased from Aug 1961, to May 9, 1968, that (I) (we) last saw the deceased alive on May 9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Harold R. Tritch, Jr. MD						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5-10-68				
22d. PHYSICIAN'S NAME (Type) Dr. Harold R. Tritch, Jr						22e. ADDRESS 302 N. Potomac St Hagerstown, Md						
23a. BURIAL CREMATION, ROSE HILL		23b. DATE 5/13/68		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.			23d. LOCATION (City or Town) HAGERSTOWN (County) WASH. (State) MD.					
24. FUNERAL DIRECTOR W. T. Konnert Hagerstown, Md.						25a. REC'D BY REGISTRAR DATE MAY 15 1968		25b. REGISTRAR'S SIGNATURE Johannes Judge				

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Harry Cunningham Wolfe			2a. DATE OF DEATH Month Day Year May 28, 1968			2b. HOUR 12:05 A.M.			
3. SEX male		4. RACE white		5. DATE OF BIRTH 12-21-1903		6. AGE (In years last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 107D Hunter Hill Drive		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Eco, Spet.		12b. KIND OF BUSINESS OR INDUSTRY Self Employed			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Wash.		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 107D Hunter Hill Drive	
14. FATHER'S NAME First Middle Last George G. Wolfe				15. MOTHER'S MAIDEN NAME First Middle Last Annie Cunningham					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 232-01-2842		17. INFORMANT Address Mrs. Eugenia R. Wolfe Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 185 X IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Adenocarcinoma of the prostate with metastasis Approximate interval between onset and death: 3 hrs. Approx. 1 yr. 6 yrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 177 X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from August 5, 1957 , to May 28, 1968 , that (I) (we) lost the deceased alive on May 28, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Donald E. Martin, M.D.				22c. DATE SIGNED 5/28/68				22d. PHYSICIAN'S NAME (Type) Donald E. Martin, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 5-29-1968		23c. NAME OF CEMETERY OR CREMATORY Lee Funeral Home		23d. LOCATION (City or Town) (County) (State) Washington, D.C.		23e. ADDRESS 363 S. Cleveland Ave., Hagerstown, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.				25a. REC'D BY REGISTRAR DATE MAY 31 1968		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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